MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08178

Reg. Dist. No. 243

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mos., 2 days

Hospital, institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution? 2 mos., 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1070 - 30th St., N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: JOHN. R. ALLEN

3.(b) Social Security Number: –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: –

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 22, 1901

8. AGE: Years	Months	Days	If less than one day
44	4	23	..... hrs. ..... min.

9. Birthplace: Loudon Co., Virginia (Town, county, and state)

10. Usual occupation: Jr. Laborer War Dept.

11. Industry or business:

FATHER — 12. Name: John R. Allen; 13. Birthplace: Virginia

MOTHER — 14. Maiden name: Ann E. Craven; 15. Birthplace: Virginia

16. Informant: Decedent

Address:

17. (Burial, cremation, or removal. Which?) Removal — Date thereof: Aug 15 45 (month) (day) (year)

Cemetery or crematory: to Wash.

Location:

18. Funeral director: John T. Thomas & Co.

Address: 901-3rd St. S.W.

19. Aug. 14 19 45 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 14 th 19 45, at 10 20 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12 th 19 45 to Aug 14th 19 45

and that I last saw h... alive on Aug 14 th 19 45

Immediate cause of death	DURATION
Pulmonary Tuberculosis	8 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Daniel Leo Pincare M.D. M. D. or other

Address: Glenn Dale, Md. Date signed: Aug 14/45

Evidence for change of year of birth of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30-1)

CERTIFICATE OF DEATH

0817?

★ Reg. Dist. No. 239

FILE No. G 98 SEP 18 1945

DO NOT USE CORPORATE TITLE IN ITEM 1

1. PLACE OF DEATH:
County Prince George
City or town Laurel
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Prince George
City or town Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No. 326 Prince George
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Wolly Arrington

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Married

6.(b) Name of husband or wife Emory L. Arrington
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 4, 1893 - 1894

8. AGE: Years	Months	Days	If less than one day
50	10	17	..... hrs. ..... min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual occupation Housework
11. Industry or business Home
12. FATHER Name C. H. Henderson
13. FATHER Birthplace Balto. Md.
14. MOTHER Maiden name Mamie A. Ridley
15. MOTHER Birthplace Balto. Md.
16. Informant Emory L. Arrington
Address 326 Prince George St. Laurel
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 24 1945 (month) (day) (year)
Cemetery or crematory Oak Hill
Location Laurel Md.
18. Funeral director H. Bell Shuldene
Address Laurel, Md.
Aug 24 1945 M. Brasheare
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 21 1945, at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 12 1937, to Aug 21 1945
and that I last saw h[illegible] alive on Aug 21 1945

Immediate cause of death	DURATION
(a) Cirrhosis with Oesophageal Hemorrhage	5 days
Due to (b) Syphilis	10 yrs
Due to (c)	
Other conditions Chr. Arteriosclerosis	3

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE J. M. Warren M.D. M. D. or other
Address Laurel Date signed 8/24/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

STATE OF MARYLAND—CERTIFICATE OF DEATH

18180

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH (WGF)

County Prince George — Registration Dist. No. 243

Village or City Bowie — No. ____ St., ____ Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 13 yrs. ____ mos. ____ ds. How long in U.S. if of foreign birth? ____ yrs. ____ mos. ____ ds.

2. FULL NAME Lloyd Herbie Baker

(a) Residence: No. ____ St., ____ Ward.

(Usual place of abode) — If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	C	Widower

5a. If married, widowed, or divorced — HUSBAND of (or) ~~WIFE of~~: Ethel Baker

6. DATE OF BIRTH (month, day, and year): Nov. 3, 1891

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	53	9	3	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: Truck Driver

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.: General Hauling

10. Date decreased last worked at this occupation (month and year): 1937

11. Total time (years) spent in this occupation: 1 yr.

12. BIRTHPLACE (city or town) (State or country): Hagerstown, Md.

FATHER

13. NAME: Unknown

14. BIRTHPLACE (city or town) (State or country): ____

MOTHER

15. MAIDEN NAME: Unknown

16. BIRTHPLACE (city or town) (State or country): ____

17. INFORMANT: Ethel Baker (Address) Bowie, Md

18. BURIAL, CREMATION, OR REMOVAL

Place Calvert Co. Md. Date Aug 9, 1945

19. UNDERTAKER: Masters Flaharty Sons (Address) Bowie Md

20. FILED Aug. 8, 1945 Mrs. J. W. Yingling Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Aug (Month) 6 (Day) 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from July, 1937, to Aug 5, 1945

I last saw him alive on Aug. 5, 1945; death is said to have occurred on the date stated above, at ____ p.m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Carcinoma of Stomach	1942

Other **Contributory Causes** of importance:

Secondary Anemia	1940
Paralysis of Comb	1940

Name of operation ____ Date of ____

What test confirmed diagnosis? ____ Was there an autopsy? ____

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ____ Date of Injury ____, 19____

Where did Injury occur? ____ (Specify city or town, county and State)

Specify whether Injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury ____

Nature of Injury ____

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify ____

(Signed) Henry A. Lee M. D.

(Address) Bowie, Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The **principal cause of death** and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The **principal cause of death** and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

Evidence for change of age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (175-e)

CERTIFICATE OF DEATH

8181

File No. G 97 AUG 31 1945

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince George
City or town: Chemerley, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, institution, or street address where death occurred: Prince George's General Hosp.
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: ~~Prince George~~ Montgomery
City or town: Burtonsville, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: World #2. ✓

3.(a) FULL NAME: Beall, LeRoy Adrian

3.(b) Social Security Number: 578-07-9703.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	single

6.(b) Name of husband or wife:

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 19 - 1903

8. AGE:

Years	Months	Days	If less than one day
41 4-2	~~10~~ 9	16 14	— hrs. — min.

9. Birthplace: Md. Burtonsville
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: Edward Beall
13. Birthplace: Md.

MOTHER
14. Maiden name: Martha Meneow
15. Birthplace: Md.

16. Informant: Mother (Mrs. Martha E. Robinson)
Address: Burtonsville. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 3-45 (month) (day) (year)
Cemetery or crematory: Union.
Location: Burtonsville, Mont. Co. Md.

18. Funeral director: Wanes & Pumphrey
Address: 8434 Ga Ave. Silver Spring. Md.

19. Aug 4 1945 (Date rec'd by registrar) Joseph M Schaff Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 3 1945, at 11 15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Toxemia	
Pneumonia	
Due to: Intus Cranial hemorrhage	
Ruptured diaphragm	
Ruptured stomach	
Bilateral pneumonia	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: As given.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of
Where did injury occur? Found (City or town) Prince (County) Md. (State)
Injured at home, farm, industry, public place (where?) Found
Means of injury: undetermined, injured at work? No

23. SIGNATURE: Deputy medical Examiner James J. Lynch M. D. or other
Address: Frederick Md. Date signed 8-3-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of year of birth of deceased is shown on FILM No. G 97 AUG 20 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(8182

Reg. Diat. No. 245

1. PLACE OF DEATH:
County Prince George
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occured:
805 Maple Ave. Takoma Park Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Layhill
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Lydia Beard.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Frank E. Beard
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 3 1879 1869

8. AGE: Years	Months	Days	If less than one day
76			..... hrs. ..... min.

9. Birthplace Maine (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Robert Marshal
13. Birthplace Maine
MOTHER 14. Maiden name Mary McNally
15. Birthplace Maine
16. Informant Mrs. Helen Jerauld
Address Layhill Md.
17. Buried (Burial, cremation, or removal. Which?) Date thereof Aug. 6th 1945 (month) (day) (year)
Cemetery or crematory Fort Lincoln
Location Wash-Balto Blvd. & D.C. line Md.
18. Funeral director Wm. J. Malley
Address 3206 Rhode Island Ave. Mt. Rainier, Md.
19. Aug. 6 1945 James Devey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 4, 1945 at ..... M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 2 1945 to Aug. 4, 1945
and that I last saw h... alive on Aug. 4, 1945

	DURATION
Immediate cause of death Cerebral hemorrhage	3 days
Due to arterio-sclerosis	Indefinite
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [illegible] M.D. M. D. or other
Address 6811 5th St. N.W. Washington, D.C. Date signed 8/4/1945

VS A15

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

8183

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County Prince Georges
City or town Cheverly, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Prince Georges General Hosp.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of motber)
State Maryland County Montgomery County
City or town Berwyn
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Beckwith, Elizabeth

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f	w	

6.(b) Name of husband or wife Elbert Beckwith
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 27 - 1882

8. AGE: Years	Months	Days	If less than one day
63	5	13	..... hrs. ..... min.

9. Birthplace Montgomery County, Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Franklin R. Margerum
13. Birthplace Pennsylvania

MOTHER
14. Maiden name Susanna Cornell
15. Birthplace Pennsylvania

16. Informant Carroll Beckwith
Address Berwyn Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-10-45 (month) (day) (year)
Cemetery or crematory Union Cemetery
Location Burtonsville Md
18. Funeral director W W Chambers & Son
Address Riverdale Md
19. 8/8 1945 Amanda Dauney
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8 1945 at 9 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 9 1945 to Aug 8 1945
and that I last saw him alive on August 7 1945
Immediate cause of death Cerebral Thrombosis
Due to Myocardial degeneration

DURATION

Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE John M Geisinger M. D. or other
Address Bruce Hsp Riverdale Date signed 8-8-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ Reg. Dist. No. 2243

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 2 mos., 26 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 1 yr., 2 mos., 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1307- 12th Street N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: BIRCH GEORGE W

3.(b) Social Security Number: 578-03-1000

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Willemina Birch

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): August 25, 1883

8. AGE: Years	Months	Days	If less than one day
61	11	7	....hrs. ....min.

9. Birthplace: Canada
(Town, county, and state)

10. Usual occupation: Stonemason

11. Industry or business:

FATHER
12. Name: George Birch
13. Birthplace: Canada

MOTHER
14. Maiden name: Clara Armstrong
15. Birthplace: Canada

16. Informant: Decedent

Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Aug 1, 1945 (month) (day) (year)

Cemetery or crematory: Washington D.C.

Location: Long Island N.Y.

18. Funeral director: W. W. Chambers

Address: 1400 Chapin St N.W.

19. Aug 1, 1945 (Date rec'd by registrar) Rowland S Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 1, 1945, at 12:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 6, 1944, to Aug 1, 1945 and that I last saw him alive on Aug 1, 1945

Immediate cause of death	DURATION
Pulmonary tuberculosis	19 mos
	17 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: Aug 1, 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1:8185

★ Reg. Diat. No. 231

1. PLACE OF DEATH:
County Prg Geo Co
City or town Heights Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Prg Geo Co
City or town Heights Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4307 — 51 Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Carrie L. Bixby.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widower

6.(b) Name of husband or wife John Bixby
8.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 2, 1861

8. AGE: Years	Months	Days	If less than one day
84			hrs. min.

9. Birthplace Lloyd New Hampshire
(Town, county, and state)
10. Usual occupation At Home
11. Industry or business

FATHER
12. Name Charles Hooper
13. Birthplace New Hampshire

MOTHER
14. Maiden name Comfort Foss
15. Birthplace New Hampshire

16. Informant Mrs E. M. Jocelyn
Address Heights Md

17. Transportation Date thereof Aug 16, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Rochester New Hampshire
Location Rochester New Hampshire
18. Funeral director I Gaccia sons
Address Hyattsville Md

19. 8/15 1945 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 14 1945, at 6:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1945, to Aug 14 1945
and that I last saw h... alive on Aug 13 1945

	DURATION
Immediate cause of death Cerebral hemorrhage	3 days
Due to	
Due to	
Other conditions Senility.	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. Chester Brady M.D.
M. D. or other
Address 34 New York Ave Date signed 8/14/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


RECEIVED
AUG 18 1995
TREAT

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

18186 Reg. Dist. No. 2-34

1. PLACE OF DEATH:
County Prince Georges
City or town Dist Heights Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Dist Heights Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 121 Washington Blvd Washington DC
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME James Wilson Blaine

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife Catherine Margaret Blaine
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 27 1866

8. AGE: Years	Months	Days	If less than one day
78	—		hrs. min.

9. Birthplace Pennsylvania (town, county, and state)
10. Usual occupation Painter, Retired
11. Industry or business St Elizabeths Hospt
FATHER 12. Name George W Blaine
FATHER 13. Birthplace Pennsylvania
MOTHER 14. Maiden name Elizabeth Hagerman
MOTHER 15. Birthplace Pennsylvania
16. Informant Emma S. Balderson
Address 121 Washington Blvd Dist Hts Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof August 23-45 (month) (day) (year)
Cemetery or crematory Forestville Episcopal
Location Forestville Maryland
16. Funeral director Thomas S. Murray
Address 2007 Nichols Ave S.E.
19. Aug 3 1945 (Date rec'd by registrar) Hugh J Beall Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 20 1945 at 6 30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 1945 to Aug 20 1945
and that I last saw him alive on Aug 19 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	Aug 1 1945 to Aug 20 1945
due to: Complete Paralysis Left Side of body	
due to: General Arteriosclerosis	Autumn
due to:	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op.
Autopsy results none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide no Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE Paul C Thurston M.D. M. D. or other
Address Washington DC Date signed Aug 20 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of year of birth of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

08187

Reg. Dist. No. 239

FILM No. G 97 AUG 20 1945

1. PLACE OF DEATH: County Prince George Co. City or town Brooklyn Bridge Rd. Laurel nd (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State md County Prince George City or town Laurel md (If outside city or town limits, write RURAL and give nearest town) Street No. Brookyn Bridge Rd. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME John S. Bayle

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	widowed

6.(b) Name of husband or wife Emma J. Bayle

6.(c) If alive, give age 1865 years

7. Birth date of deceased (mo., day, yr.) Dec - 9 - 78-6-6-

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
79				

9. Birthplace Baltimore md (Town, county, and state)

10. Usual occupation Retired Bank watchman

11. Industry or business U S Navy yard Washdc

FATHER 12. Name Jno Bayle

FATHER 13. Birthplace md

MOTHER 14. Maiden name Susan Stokey

MOTHER 15. Birthplace md

16. Informant Alice L. Bayle Hoke

Address Laurel md Box 300

17. Buried (Burial, cremation, or removal. Which?) Date thereof 8-7-45 (month) (day) (year)

Cemetery or crematory Joy Hill cemetery

Location Laurel md

18. Funeral director New Chambers Co

Address Riverdale md

19. August 4 1945 Chas E. Wachter Registrar (Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-4 1945, at 1045a m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/22 1945, to 8/4 1945 and that I last saw h alive on 8/4 1945

Immediate cause of death	DURATION
Coronary Thrombosis	3
Coronary arteriosclerosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W H Lemmon M. D. or other

Address Laurel Date signed 8/4/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

08188

★ Reg. Dist. No. 239

WITHIN CORPORATE LIMITS

1. PLACE OF DEATH:
County: Pr Geo
City or town: Laurel Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pr Geo
City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No. 410 Pr Geo St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Leslie Russell Brady

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Marie Brady
6.(c) If alive, give age ..... years

7. Birth data of deceased (mo., day, yr.): Nov 4 1905

8. AGE: Years	Months	Days	If less than one day
39	9	11	..... hrs. ..... min.

9. Birthplace: Md.
(Town, county, and state)
10. Usual occupation: Radio Engineer
11. Industry or business:
FATHER 12. Name: Harry R. Brady
13. Birthplace: Martinsburg W. Va
MOTHER 14. Maiden name: May Kelley
15. Birthplace: Martinsburg W. Va
16. Informant: Marie Brady
Address: 410 Pr Geo St.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 18-1945 (month) (day) (year)
Cemetery or crematory: Nat Cap Meth Pk
Location: Laurel Md
18. Funeral director: DeWitt Donaldson
Address: Laurel Md
19. Aug 18 1945 (Date rec'd by registrar) M. Brashears Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 15 1945, at 2:45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 26 1936, to August 15 1945
and that I last saw b... alive on August 15 1945

Immediate cause of death	DURATION
Lobar pneumonia	9 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

~~22.~~ VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Robert S Dewey MD M. D. or other
Address: 402 Main St Laurel Md Date signed: 8/17/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (22-6)

CERTIFICATE OF DEATH

08190

★ Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Prince George
City or town Cheverly, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 42 min.
Hospital, institution, or street address where death occurred:
How long in hospital or institution? 42 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Prince George
City or town Brentwood
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3720 Jackson ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME William Wesley Brady

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widow

6.(b) Name of husband or wife Agnes Morris
6.(c) If alive, give age ..... years
7. Birthdate of deceased (mo., day, yr.) June 3, 1865
June 3, 1867

8. AGE: Years 80 | Months 2 | Days 15 | If less than one day ..... hrs. ..... min.

9. Birthplace Md. (Town, county, and state)
10. Usual occupation Retired
11. Industry or business
FATHER 12. Name George Brady
13. Birthplace Md.
MOTHER 14. Maiden name Charlotte Beall
15. Birthplace Md.
16. Informant Mrs Elizabeth C. Bendure
Address University Park Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 21, 1945 (month) (day) (year)
Cemetery or crematory Epiphany Church Cemetery
Location Forrestville Md.
18. Funeral director W.W. Chambers Co.
Address Riverdale, Md
19. 8/19 (Date rec'd by registrar) 19 45 Amanda Denney Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18 19 45 at 7:19 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 18 19 45 to Aug 18 19 45 and that I last saw h.. alive on Aug 18 19 45

Immediate cause of death	DURATION
Toxemia	
Due to Uremia	
Due to intestinal obstruction	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results Pelvic adhesions producing intestinal obstruction
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE John M. Jernigan M. D. or other
Address Bruce & George Clin Hosp. Date signed 8-19-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

CERTIFICATE OF DEATH

08189

★ Reg. Dist. No. 2 4 3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince Georges

City or town: Fox's Landing

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Transient

Hospital, institution, or street address where death occurred: Potomac River

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Virginia County:

City or town: Alexandria

(If outside city or town limits, write RURAL and give nearest town)

Street No. 423 North Henry

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Robert Lindsey Brantley

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	married

6.(b) Name of husband or wife: Eva May Brantley

6.(c) If alive, give age: 26 years

7. Birth date of deceased (mo., day, yr.): 1910

8. AGE: Years	Months	Days	If less than one day
35			hrs. min.

9. Birthplace: Waynesboro, Georgia (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER — 12. Name: Ruben Brantley

13. Birthplace: Augusta, Georgia

MOTHER — 14. Maiden name: Mabella Gardner

15. Birthplace: Unknown

16. Informant: Eva May Brantley

Address: 4613-8th Rd, South Arlington, Va

17. Removal (Burial, cremation, or removal. Which?) Date thereof 8-5-45 (month) (day) (year)

Cemetery or crematory: Rhines Funeral Home

Location: Washington, D.C.

18. Funeral director: F. Gadsch's Sons

Address: Rockville, Md.

19. 8/5/45 (Date rec'd by registrar) 19 Thos D. Griffith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 3 19 45 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Asphyxia	
Due to: Drowning	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide? undetermined Date of Unknown

Where did injury occur? Unknown (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner

23. SIGNATURE: James L. Long M. D. or other

Address: Westville Md. Date signed 8-5-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

08191

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Near Bowie P. Geo.
City or town: (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 65 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: P. Geo.
City or town: near Bowie
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: James Brooks

3.(b) Social Security Number: none

4. Sex: Male
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of ~~husband~~ or wife: Sophie Brooks
6.(c) If alive, give age: Dead years
7. Birth date of deceased (mo., day, yr.): unknown

8. AGE: Years: 65 Months: — Days: — If less than one day: hrs. min.

9. Birthplace: near Bowie, P. Geo. Md. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Laborer
FATHER 12. Name: Lewis Brooks
13. Birthplace: near Bowie Md
MOTHER 14. Maiden name: Rachel Thomas
15. Birthplace: Bowie. P. Geo. Co.
16. Informant: Lewis Brooks
Address: mitchellville. Md.
17. buried (Burial, cremation, or removal. Which?) Date thereof aug 9. 1945 (month) (day) (year)
Cemetery or crematory: Holy Family
Location: mitchellville Md
19. Funeral director: Clarence Foreacre
Address: Mitchellville Md
19 August 8 1945 Mrs J. W. Yingling Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 6 1945, at 10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 2 1945 to August 6 1945 and that I last saw h~~im~~ alive on Aug. 6 1945

Immediate cause of death	DURATION
Cardio-Vascular renal	
Due to: Clinical Cardiac arrest	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: G E Lancaster M D (M. D. or other)
Address: Bowie Md Date signed: aug. 7/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

8192

★ Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince Geo

City or town: Bladensburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
4927 Edmonston Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County:

City or town:
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4927 Edmonston Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME
CORELIA. BROOME

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
55			hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER
12. Name: John Brooms
13. Birthplace: Md.

MOTHER
14. Maiden name: unknown
15. Birthplace: Md

16. Informant: Phillip Broom
Address: 4227 Edmonston Ave

17. Removal (Burial, cremation, or removal. Which?) Date thereof Aug. 23, 1945 (month) (day) (year)

Cemetery or crematory

Location: Washington, D.C.

18. Funeral director: W Ernest Jarvis Co.
Address: 1432 You St N W

19. Aug 23 1945 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 22 19 45, at 11:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 19 45, to Aug 22 19 45

and that I last saw her alive on Aug 22 19 45

Immediate cause of death	DURATION
Heart failure	week
Due to: Hypertension	?
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W L Hudson M.D. M. D. or other

Address: Laurel Md Date signed Aug 23 '45

08193

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (837)

CERTIFICATE OF DEATH

Reg. Dist. No. 245.

1. PLACE OF DEATH:
County: Pro Geo Co—
City or town: Berwyn Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pro Geo Co
City or town: Cheverly Md:—
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1800—64 ave.;
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Lura B. Buck:

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Arthur P. Buck
6.(c) If alive, give age: 77 years
7. Birth date of deceased (mo., day, yr.): March 22. 1869

8. AGE: Years	Months	Days	If less than one day
76			hrs. min.

9. Birthplace: Illinois (Town, county, and state)
10. Usual occupation: Retired school teacher
11. Industry or business

FATHER
12. Name: Calvin N. Baker
13. Birthplace: Illinois

MOTHER
14. Maiden name: Rebecca Winner
15. Birthplace: Pennsylvania

16. Informant: Arthur P. Buck
Address: Cheverly Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: Aug 20. 1945 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cemetery
Location: Suitland Md

18. Funeral director: F. Gasch's sons
Address: Hyattsville Md

19. Aug 20 1945 (Date rec'd by registrar) James Berry Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 18. 1945 at 6.15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-3-45 19.. to 8-18 19.45
and that I last saw h. alive on 8-18-45 19..

Immediate cause of death	DURATION
Cerebral Thrombosis	2 wks
Due to: Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John P Clum M.D.
M. D. or other
Address: Hyattsville Date signed: 8-17-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

08194

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 242

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Prince Georges

City or town Rosamville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Ten years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Rosamville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ella Cecilia Burroughs

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 1, 1934

8. AGE: Years 11 | Months 8 | Days 14 | If less than one day ..... hrs. ..... min.

9. Birthplace Brandywine, Md.

(Town, county, and state)

10. Usual occupation Student

11. Industry or business School

FATHER 12. Name Joseph Burroughs

13. Birthplace Maryland

MOTHER 14. Maiden name Ola Downing

15. Birthplace Maryland

16. Informant Mrs. Ola Burroughs

Address Rosamville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 18-8-1945 (month) (day) (year)

Cemetery or crematory J. B. Maryland

Location T. B. Maryland

18. Funeral director Arthur L. Rollins

Address 4339 Hunt Pl. N.E.

18-15-45 19..... Irene A. Bowers

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 1945 at 8:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Tetanus	
Due to Pneumonia, Bronchial	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE as R Boyd M. D. or other

Address Forestville Md Date signed 5-14-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

68195

★ Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 mo., 27 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 1 mo., 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2023 Bennings Rd. N. E.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: CHARLES A. BUSEY

3.(b) Social Security Number: 578-20-3393

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Louise Busey
6.(c) If alive, give age: 21 years

7. Birth date of deceased (mo., day, yr.): February 6, 1920

8. AGE: Years	Months	Days	If less than one day
25	6	3	hrs. min.

9. Birthplace: Pittsburgh, Pennsylvania
(Town, county, and state)
10. Usual occupation: Truck Driver
11. Industry or business:

FATHER
12. Name: Frederick W. Busey
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Laura Hanson
15. Birthplace: Pennsylvania

16. Informant: Decedent
Address:

17. removal (Burial, cremation, or removal. Which?) Date thereof: Aug 9 1945 (month) (day) (year)
Cemetery or crematory:
Location: To Washington D.C.
18. Funeral director: W W Chamber Undertaker
Address: 517 11th St NE

19. Aug 9 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: AUGUST 9 1945, at 6:25 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 13 1945, to AUG. 9 1945, and that I last saw h.. alive on AUG. 9 1945

Immediate cause of death	DURATION
PULMONARY TUBERCULOSIS	10 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale, Md., Date signed: 8/9/45

(M) MARGIN RESERVED FOR BINDING (1)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

68196

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George's County

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mos., 22 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 3 mos., 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 720 L. Street S. E.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: GABRIEL BUTLER

3. (b) Social Security Number: 579-32-3045

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: –

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 8, 1921

8. AGE: Years	Months	Days	If less than one day
24	–	13	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Edward Logan
13. Birthplace: ?

MOTHER
14. Maiden name: Ethel Butler (unmarried)
15. Birthplace: St. Mary's Co., Maryland

16. Informant: Decedent
Address:

17. Removal to Wash, D.C. (Burial, cremation, or removal, Which?) Date thereof: Aug 22 1945 (month) (day) (year)

Cemetery or crematory:

Location: Removal to Washington D.C.

18. Funeral director: John T Rhine

Address: 901 3 St S.W. Rep of B. Realty

19. Aug 21, 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 21st 1945, at 3:35 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 30 1945 to August 21 1945 and that I last saw him alive on August 21st 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	1 yr
Due to:	4½ mos.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Linnane M.D. M. D. or other

Address: Glenn Dale, Md. Date signed: 8/21/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

08197

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45-8) d

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:
County Prince Georges County
City or town 6470 Allentown Road Washington 20 DC
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? July 1 1945
Hospital, institution, or street address where death occurred:
6470 Allentown Road Washington 20 DC
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town 6470 Allentown Road -
(If outside city or town limits, write RURAL and give nearest town)
Street No. Washington 20 DC
(If rural, give LOCATION)
2.(a) If veteran, name war Spanish American

3. (a) FULL NAME Thomas O Day

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 7 1871

8. AGE: Years 73 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Prince Georges Co (Town, county, and state) Maryland

10. Usual occupation Flowerest Laborer

11. Industry or business Soldiers Home.

FATHER — 12. Name Thomas O Day

FATHER — 13. Birthplace Maryland

MOTHER — 14. Maiden name Unk White

MOTHER — 15. Birthplace Clinton Md.

16. Informant Jessie A Day (Cousin)
Address 6470 Allentown Rod DC 20

17. Burial (Burial, cremation, or removal? Which?) Date thereof 8-21-45 (month) (day) (year)
Cemetery or crematory Bells Chapel
Location Camp Springs Md

18. Funeral director W. W. Chambers Co.
Address 517 11th St S.E.

19. 8/18/45 (Date rec'd by registrar) Thos S Griffith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 18 1945 at 11 55 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 13 1945 to Aug 18 1945
and that I last saw him alive on Aug 18 1945

Immediate cause of death	DURATION
Hemorrhage from ulcerated area in mouth	6 hours
Due to Carcinomatosis of Peritoneum, primary	
Due to Epithelioma	18 years
Other conditions None of note	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op. —
Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) no
Means of injury — Injured at work?

23. SIGNATURE Paul C Van Hatten M. D. or other
Address Washington DC Date signed Aug 18 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Md.)

08198

CERTIFICATE OF DEATH

Reg. Dist. No. 234

1. PLACE OF DEATH:

County: Prince Georges

City or town: Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Permanent

Hospital, institution, or street address where death occurred: Intersection of Central Ave and Crain Highway

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 352 Anacostia Rd SE

(If rural, give LOCATION)

2.(a) If veteran, name war: V

3. (a) FULL NAME: James Adrion Dell

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 7, 1924

8. AGE: Years: 20 | Months: 8 | Days: 9 | If less than one day: hrs. min.

9. Birthplace: Laurel, Md (Town, county, and state)

10. Usual occupation: Sailor U.S.N.R.

11. Industry or business:

FATHER — 12. Name: Clayton V Dell

13. Birthplace: Westminster, Md

MOTHER — 14. Maiden name: Elizabeth L. Gilbert

15. Birthplace: Havre de Grace, Md

16. Informant: Mrs. Catherine Lankford

Address: 352 Anacostia Rd DC

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 20-1945 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington Va

18. Funeral director: Lee W Ware Co. Inc.

Address: 2700 M St N.W.

19. August 16 1945 Howard I Bradd

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 16 1945 at 2:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Hemorrhage Shock	
Due to: Fracture of skull	
Fracture and dislocation	D
Due to: Comminuted vertebrae	
Other conditions: Fracture Upright & Lamina fracture of left Clavicle & fibula	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 8-16-45

Where did injury occur? Hall's (City or town) P.G. (County) Md (State)

Injured at home, farm, industry, public place (where?): State Road

Means of injury: Driver of Motorcycle Injured in collision

Especially needed Expansion

23. SIGNATURE: [signature] M. D. or other

Address: Forestville Md Date signed: 8-16-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

08199

Reg. Dist. No. 246

1. PLACE OF DEATH:

County: Prince Georges

City or town: Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, Institution, or street address where death occurred:

Leland Memorial Hospital

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: College Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 7206 Bowdoin Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Mary Estelle Denton

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 10, 1890

8. AGE:

Years	Months	Days	If less than one day
55	5	9	hrs. min.

9. Birthplace: Arkansas (Town, county, and state)

10. Usual occupation: inspector

11. Industry or business: Washington Institute Tech

FATHER

12. Name: Frank Delsha Denton

13. Birthplace: Arkansas

MOTHER

14. Maiden name: Martha A Lewis

15. Birthplace: Mississippi

16. Informant: Hospital Records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 21, 1945 (month) (day) (year)

Cemetery or crematory:

Location: Memphis, Tenn

18. Funeral director: St. A. Chambers Co.

Address: Riverdale, Md.

19. August 20, 1945 (Date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 19, 1945, at 3:08 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 17, 1945, to Aug. 19, 1945 and that I last saw her alive on Aug. 19, 1945

	DURATION
Immediate cause of death: Generalized Peritonitis	2 days
Due to: Pelvic Abscess	1 wk. (?)
Due to: Pyometrium & Salpingitis.	2 wks. (?)
Other conditions: Gangrenous appendicitis, acute, Perforated	4 days

(Include pregnancy within 3 months of death)

Major findings of operations: Ac. Gangrenous Appendicitis; Gen. Peritonitis, Pelvic Abscess. Date of op. 8-18-45

Autopsy results: as above, & Pyometrium.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Herman D. Slade M. D. or other

Address: 4408 Lowenburg Rd. Riverdale, Md. Date signed: 8-20-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Md)

08200

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH: Prince Georges General Hospital

County Prince George's

City or town Cheverly Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 days

Hospital, institution, or street address where death occurred:

Prince George General Hospital

How long in hospital or institution? 30 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George

City or town P.O. Landover Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. Southern Ave Seat Pleasant Md

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Thomas A. Dobyns.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	m.

6.(b) Name of husband or wife Maria Berry Dobyns.

6.(c) If alive, give age 80 years

7. Birth date of deceased (mo., day, yr.) Sept. 3, 1861

8. AGE:

Years	Months	Days	If less than one day
83	11	26	hrs. min.

9. Birthplace Tappahannock, Essex County, Virginia (Town, county, and state)

10. Usual occupation Pharmacist

11. Industry or business

FATHER 12. Name Thomas A Dobyns

13. Birthplace Va

MOTHER 14. Maiden name Lucy Singer

15. Birthplace

16. Informant Thos A. Dobyns.

Address 5- Worthington Dr. Washington D.C.

17. [redacted] (Burial, cremation, or removal. Which?) Date thereof Aug 29 1945 (month) (day) (year)

Cemetery or crematory St. Barbaras

Location Leeland, Md.

18. Funeral director F. Gasaches Sons

Address Bladensburg Md

19. 8/27 1945 (Date rec'd by registrar) Amanda P. Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 26 1945 at 12:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 28 1945 to Aug 26 1945 and that I last saw ... alive on Aug 25 1945

Immediate cause of death	DURATION
Cerebral hemorrhage	2 days
Due to Senility	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury Injured at work?

23. SIGNATURE R. Apgar M. D. or other

Address P.O. Seat Pleasant Md Date signed Aug 26/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186a)

CERTIFICATE OF DEATH

08201

Reg. Dist. No. 248

1. PLACE OF DEATH:

County: Prince George

City or town: Hyattsville Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Permanent

Hospital, institution, or street address where death occurred: Leland Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2200 16th St. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Alexander Allman Dow

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Helen Hayes Dow

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 29, 1904.

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
41				

9. Birthplace: Pittsburg, Penna. (Town, county, and state)

10. Usual occupation: Engineer Bur. of Mines

11. Industry or business: U.S. Govt.

FATHER

12. Name: Oswald B. Dow

13. Birthplace: Guelph, Ont. Canada.

MOTHER

14. Maiden name: Mary E. Aikman

15. Birthplace: Windsor, Canada

16. Informant: Mrs. Helen Hayes Dow

Address: 2200 16th St. N.W. Wash. D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 23 1945 (month) (day) (year)

Cemetery or crematory: Cemetery

Location: Grove City Pa

18. Funeral director: Jos. Gawler's Sons

Address: 1754 K St Ave N.W.

19. Aug 22 1945 James Seery

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 21 1945 at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Cerebral Compression	
Due to: Intra Cranial hemorrhage	
Due to: Fracture of base of skull	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 8-21-45

Where did injury occur? Hyattsville (City or town) Prince Geo. (County) Md. (State)

Injured at home, farm, industry, public place (where?): In Hyattsville Jail

Means of injury: Fell down stair Injured at work? no

Repeat medical Examiner

23. SIGNATURE: James E. Ford M.D. or other

Address: Forestville, Md. Date signed: 8-22-45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MINOR CHANGES INADDRESS: Informan'ts letter filmed 8-31-45 G97 - L

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-e)

08202

CERTIFICATE OF DEATH

Reg. Diat. No. 231

1. PLACE OF DEATH:
County Prince Georges
City or town Columbia Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Transient
Hospital, institution, or street address where death occurred:
Palmers Maryland Highway
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State District of Columbia County
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4405 B 40-53d Place 46th Place NE (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John Wesley Dorsey

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	married

B.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 27, 1902

8. AGE: Years	Months	Days	If less than one day
43	5	17	hrs. min.

9. Birthplace District of Columbia (Town, county, and state)
10. Usual occupation Clerk
11. Industry or business Interior Dept wash DC

FATHER
12. Name Andrew L Dorsey
13. Birthplace Virginia

MOTHER
14. Maiden name Adell Walter
15. Birthplace District of Columbia

16. Informant Francis D Dorsey
Address 4053 40-53d Place 46th Place NE

17. removal (Burial, cremation, or removal. Which?) Date thereof Aug 16. 1945 (month) (day) (year)
Cemetery or crematory McGuire's Funeral Home
Location 1820-9th st N.W Washington DC

18. Funeral director L Gascho Sons
Address Hyattsville Md

19. 8/16 1945 Amanda Downey
(Date recd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 16 1945 at 1:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Hemorrhage	
Shock	
Due to Crushed skull	
Compound fracture left temp & fore	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 8-16-45
Where did injury occur? Columbia Park (City or town) Prince Georges (County) Md (State)
Injured at home, farm, industry, public place (where?) State Road
Means of injury pedestrian Struck by a car Injured at work? no

Deputy medical Examiner
23. SIGNATURE Thomas J Bond M. D. or other
Address Hyattsville Md Date signed 8-16-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


RECEIVED
AUG 18 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08203

★ Reg. Dist. No. 248

1. PLACE OF DEATH:

County Prince Georges.

City or town Riverdale, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 mo - 10 days

Hospital, institution, or street address where death occurred:

Eugene Leland Memorial Hospital

How long in hospital or institution? 160 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Hyattsville, Maryland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4008 Quintana Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Reinette Dunn.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 12, 1923

8. AGE: Years	Months	Days	If less than one day
22	3	20	..... hrs. ..... min.

9. Birthplace New York (Town, county, and state)

10. Usual occupation Aud. & clerk

11. Industry or business Woodward & Lothrop.

FATHER 12. Name Stanley Smith Dunn

13. Birthplace New York

MOTHER 14. Maiden name Mabelle L. Kanphear

15. Birthplace Wisc.

16. Informant pt's chart.

Address

17. Aug-4-45 (Burial, cremation, or removal. Which?) Date thereof Burial (month) (day) (year)

Cemetery or crematory Md. Mem. Pk Cemetery

Location Falls Church, Va.

18. Funeral director Low Chambers

Address Riverdale, md

19. August 2 1945 (Date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 1, 1945, at 3 55 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 21 1945, to Aug 1 1945 and that I last saw h.. alive on July 31 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	15 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE L. W. Mahon M.D. M. D. or other

Address Riverdale, Md Date signed 8-1-45

M

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (16-HC)

CERTIFICATE OF DEATH

Reg. Dist. No. 18214 234

1. PLACE OF DEATH:
County: Prince George
City or town: Oxon Hill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place at death? Transient
Hospital, Institution, or street address where death occurred: 4793 Wheeler Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Oxon Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4900 Wheeler Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Kenneth Clayes Fletcher

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 30, 1913

8. AGE: Years: 31 Months: 11 Days: 2 If less than one day: hrs. min.

9. Birthplace: Maryland (City, county, and state)

10. Usual occupation: Builder

11. Industry or business:

FATHER
12. Name: Charles Clayes Fletcher
13. Birthplace: New York

MOTHER
14. Maiden name: Lula Zachenmeyer
15. Birthplace: Nebraska

16. Informant: Mrs C. Moore
Address: 4801 Wheeler Road S.E.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 3 1945 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington Va
Funeral director: Thomas F. Murray
Address: 2007 Nichols Ave S.E.

19. Aug 2 1945 (Date received by registrar) Howard I Bevel Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 1, 1945, at 4:P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Hemorrhage	
Shock	
Due to: Gunshot wound of head	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of: 8-1-45
Where did injury occur? Oxon Hill Prince George Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): In yard of home
Means of injury: Gun shot Injured at work?

Deputy medical Examiner

23. SIGNATURE: M. D. or Other
Address: Forestville Md Date signed: 8-1-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for change of date of birth of deceased is shown on FILM NO. G97 SEP 10 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (87-2)

CERTIFICATE OF DEATH

08205

★ Reg. Dist. No. 230

1. PLACE OF DEATH:
County Pr. Geo. Co.
City or town Greenbelt
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State Md. County Pr. Geo
City or town Greenbelt
(If outside city or town limits, write RURAL and give nearest town)
Street No. 15 - B. Laurel Hill Rd
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Earl M. Frederick

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Estelle Frederick
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 3 - 1896

8. AGE: Years	Months	Days	If less than one day
48			hrs. min.

9. Birthplace: Janesville, Wis.
(Town, county, and state)
10. Usual occupation:
11. Industry or business: Sanitary Engineer Dept of Agric.

FATHER
12. Name: John Wm Frederick
13. Birthplace: Wis

MOTHER
14. Maiden name: Mary C. Madeuse
15. Birthplace: Wis

16. Informant: Clarence S. Kelleher
Address: Research Center Laboratory Beltsville

17. Buried (Burial, cremation, or removal. Which?) Date thereof 8-29-45 (month) (day) (year)
Cemetery or crematory: Mt. Olivet
Location: Waukon, Iowa

18. Funeral director: W W Chandler & Co
Address: Riverdale, Md.

19. August 29 1945 (Date rec'd by registrar) James Berry Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 29 1945 at 2:45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 23, 1945, to August 28, 1945
and that I last saw h. alive on August 24, 1945

Immediate cause of death	DURATION
Cardiovascular Hypertension	3 years
Due to: Skull fracture 5 years ago	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Hans Wodeke, M.D.
M. D. or other
Address: 30-D Ridge Rd, Greenbelt Md. Date signed: 8-29-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08206

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince George

City or town: North Brentwood

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, institution, or street address where death occurred:

4510 - Church Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: North Brentwood

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4510 - Church Street

(If rural, give LOCATION)

2.(a) If veteran, name war: World War #1

3.(a) FULL NAME: John Wilson Gillispie

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Colored	married

6.(b) Name of husband or wife: Maria Gillispie

6.(c) If alive, give age: 34 years

7. Birth date of deceased (mo., day, yr.): April 1, 1901

8. AGE: Years: 44 | Months: 4 | Days: 6 | If less than one day: ..... hrs. ..... min.

9. Birthplace: North Carolina (Town, county, and state)

10. Usual occupation: Hauling

11. Industry or business

FATHER — 12. Name: John G. Gillispie

FATHER — 13. Birthplace: South Carolina

MOTHER — 14. Maiden name: Mary C. Calhoun

MOTHER — 15. Birthplace: South Carolina

16. Informant: Dessie Smith

Address: Route #1 Box 98. Hamlet, N.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 11/45 (month) (day) (year)

Cemetery or crematory: Lincoln Memorial

Location: Suitland, Md.

16. Funeral director: John T. Stewart

Address: 30 - H St. N.E. Wash, D.C.

19. Aug. 7 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 7 1945 at 1:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Cerebral Compression	
Due to: Causes of Brain	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Deputy Medical Examiner

M. D. or other

Address: Forestville Md. Date signed 8-7-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlee St., Baltimore (107)

CERTIFICATE OF DEATH

118217

Reg. Diat. No. 232

1. PLACE OF DEATH:

County Prince Georges

City or town Cheltenham

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Cheltenham

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war Spanish American

3. (a) FULL NAME Henry Lee Grant

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife Pleasant Davis Grant. Deceased 6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 7 1852

8. AGE:

Years	Months	Days	If less than one day
92			..... hrs. ..... min.

9. Birthplace Lost Creek West Virginia (Town, county, and state)

10. Usual occupation Retired Cpl. U.S. Army

11. Industry or business U.S. Army

FATHER

12. Name Wm S Grant.

13. Birthplace unknown

MOTHER

14. Maiden name Mary Lyons

15. Birthplace Cul Hopeful, Va.

16. Informant Mary Patricia Grant

Address Cheltenham Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 26 1945 (month) (day) (year)

Cemetery or crematory Chapel Hill Memorial Park

Location Cheltenham Md

16. Funeral director Grant & Dyson

Address Walker Md

19. Aug 24 1945 (Date rec'd by registrar) R E Grant Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 23 1945, at 2.30 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 15 1945 to Aug 23 1945 and that I last saw h.. alive on Aug 23 1945

Immediate cause of death	DURATION
Acute Bronchopneumonia	2 days
Due to, Acute myocarditis with Pulmonary edema	8 days
Due to, General Arteriosclerosis and Malnutrition	many years
Other conditions Fracture of left hip (Include pregnancy within 3 months of death)	1 yr

Major findings of operations — none

Date of op. none

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following; no

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work? —

23. SIGNATURE Paul C Van Hatten M. D. or other

Address Washington 19th Date signed Aug 24 1945

M

1

2

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

CERTIFICATE OF DEATH

8208

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince George

City or town: Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 years

Hospital, Institution, or street address where death occurred: 6304 Taylor Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Riverdale

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6304 - Taylor Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Anton Gusiak

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Beulah Gusiak

6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): March 4, 1880

8. AGE:	Years	Months	Days	If less than one day
	65	5	10	...hrs. ...min.

9. Birthplace: Austria (Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: Building

FATHER — 12. Name: Unknown

FATHER — 13. Birthplace: Austria

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Austria

16. Informant: Mrs. Beulah Gusiak

Address: 6304 Taylor Road, Riverdale Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 18, 1945 (month) (day) (year)

Cemetery or crematory: Fort Lincoln

Location: Colmar Manor Md

18. Funeral director: L. Gasch's Sons

Address: Hyattsville Md.

19. Aug. 16, 1945 (Date rec'd by registrar) James Devery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 14 1945 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19... to ...19...

and that I last saw h... alive on ...19...

Immediate cause of death	DURATION
Coronary Occlusion	
Due to Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Deputy medical Examiner Richard J. Bard M. D. or other

Address: Forestville Md Date signed 8-15-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08209

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince Georges

City or town: Queen Anne Bladensburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 months

Hospital, institution, or street address where death occurred:
2023 - Ravenswood Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Queen Anne Bladensburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2023 Ravenswood Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Francis Foster Hall

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 25, 1868

8. AGE: Years: 77 | Months: 3 | Days: 23 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Massachusetts
(Town, county, and state)

10. Usual occupation: Shoe maker

11. Industry or business

FATHER
12. Name: Martin Van Buren Hall
13. Birthplace: Massachusetts

MOTHER
14. Maiden name: Mary Chesebrough
15. Birthplace: Massachusetts

16. Informant: Miriam E. Roth

Address: 2023 Ravenswood Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof: August 22, 1945 (month) (day) (year)

Cemetery or crematory: Whitman Cemetery.

Location: Whitman Mass.

16. Funeral director: Arthur Stalker.

Address: 254 Carroll St. N.W. Takoma Park, D.C.

19. Aug 18 1945 James Seery
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 18 1945, at 10:08 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Congestive heart failure	
Due to: Cardiosclerosis	
Due to: Senile decay	
Other conditions: Right hemi plegia	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Deputy medical Examiner
M. D. or other

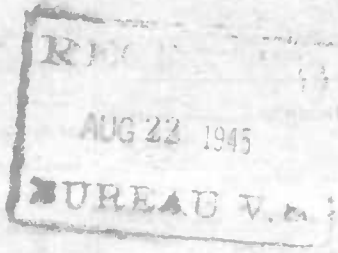
Address: Forestville Md. Date signed: 8-18-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (75)

CERTIFICATE OF DEATH

08210

★ Reg. Dist. No. 231

M

1

T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Prince Geo. Co.

City or town Cheverly-Hyattsville Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Prince Geo. Gen. Hosp.

How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Prince Geo.

City or town Hyattsville Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4114 Gallatin St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME James Whittingham Hammett.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	White	Widowed.

6.(b) Name of husband or wife Helen Buchanan deceased. 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 15-1892

8. AGE: Years	Months	Days	If less than one day
53	1	26	..... hrs. ..... min.

9. Birthplace Wash. D.C. (Town, county, and state)

10. Usual occupation Engineer Dept. Md.

11. Industry or business

FATHER 12. Name James Whittingham Hammett

13. Birthplace Md.

MOTHER 14. Maiden name Mary Jane Cogan

15. Birthplace Wash. D.C.

16. Informant T. Cogan Hammett

Address 2009 N. St N.E. Wash. D.C.

17. Burial Date thereof Aug 13, 1945

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Ft Lincoln

Location Colmar Manor Md

18. Funeral director F. Gasch's Sons

Address Hyattsville Md.

19. Aug 13 1945 Amanda J Downey

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10 1945 at 9:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 5 1945, to August 10 1945

and that I last saw him alive on Aug 10 1945

Immediate cause of death	DURATION
Vascular Encephalopathy	
Vascular Collapse	
Due to Hypertensive Cardio-Vascular Renal	
Due to	
Other conditions Marked Cerebral Edema	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Cardiac Hypertrophy cerebral

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address Hyattsville Md Date signed 8-11-45

08211

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 242

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

I. PLACE OF DEATH:

County: Prince Georges

City or town: Hillside rfd

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yr

Hospital, institution, or street address where death occurred:

[illegible]

How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Hillside (Capital Heights) rfd

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1214 - 59th ave

(If rural, give LOCATION)

2.(a) If veteran, name war: none

3. (a) FULL NAME: Phillip Harich

3. (b) Social Security Number: 220-09-0234

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	married

6.(b) Name of husband or wife: Magdalena Mattern Harich

6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): Sept 25 1881

8. AGE: Years	Months	Days	If less than one day
63			....hrs. ....min.

9. Birthplace: Jugoslavia (Town, county, and state)

10. Usual occupation: Bricklayer

11. Industry or business: Retired

FATHER 12. Name: Phillip Harich

FATHER 13. Birthplace: Jugoslavia

MOTHER 14. Maiden name: Elizabeth Schwalb

MOTHER 15. Birthplace: Jugoslavia

16. Informant: Fidrea Newton

Address: 220 - 59th Ave Capitol Heights Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-31-45 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Suitland Md.

18. Funeral director: W. W. Chambers Co.

Address: 517 11th St S.E.

19. Aug 30, 1945 (Date rec'd by registrar) Irene A. Bonner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 28, 1945, at 11:50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 27, 1945, to Aug 28, 1945 and that I last saw him alive on Aug 27, 1945

Immediate cause of death	DURATION
Pulmonary Hemorrhage	3 days
Due to: Ulcer Larynx Unknown	
Probably Pulmonary TB	unknown
Due to:	
Other conditions: unknown	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.:

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide: ~~nt~~ Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) no

Means of injury none. Injured at work? no

23. SIGNATURE: Paul C Van Natta M. D.

Address: Washington 19 DC Date signed: Aug 28, 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45)

08212

CERTIFICATE OF DEATH

Reg. Diat. No. 231

1. PLACE OF DEATH:
County: Prince George Co.
City or town: Cottage City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Cottage City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3709 Cottage Terrace
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: AMANDA ELISA HELMS

3.(b) Social Security Number: 577-30-1516

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Sylvester

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): December 14 1893

8. AGE: Years	Months	Days	If less than one day
51			..... hrs. ..... min.

9. Birthplace: New Jersey (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Retired Clerk Dept of Defense

12. FATHER — Name: Christian A. Christiansen

13. FATHER — Birthplace: Norway

14. MOTHER — Maiden name: Georgina Pettersen

15. MOTHER — Birthplace: Norway

16. Informant: Mrs. Sylvia A. Iliff

Address: 3709 Cottage Ter.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 18 1945 (month) (day) (year)

Cemetery or crematory: High Hill Cemetery

Location: Monroe N.C.

18. Funeral director: J. William Sullivan Sons & Co.

Address: 300 - 4 St. N.E. Wash. D.C.

19. 8/18/45 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8/17 19 45, at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/15 19 45, to 8/17 19 45 and that I last saw h.CR alive on 8/17 19 45

Immediate cause of death	DURATION
Carcinoma of Pancreas	
Malnutrition	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: George Magruder M.D. M. D. or other

Address: 3717 - 39th St. N.W. Date signed: 8/17/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

08213

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (122-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 231

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Prince George
City or town Cheverly, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 hrs. 15 min.
Hospital, institution, or street address where death occurred: Prince George Hospital
How long in hospital or institution? 15 hrs. 15 min

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George
City or town Edmonston
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5008 52nd. ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mrs. Anna Margaret Hiser

3. (b) Social Security Number

4. Sex F
5. Color or race W
6.(a) Single, married, widowed, or divorced ✓
6.(b) Name of husband or wife John Hiser
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) May 17 1871
8. AGE: Years 74 Months Days If less than one day ... hrs. ... min.
9. Birthplace Germany (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name ? —
13. Birthplace Germany
MOTHER 14. Maiden name —
15. Birthplace Germany
16. Informant John Henry Hiser
Address 9308 Georgetown Rd. Bethesda Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 4. 1945 (month) (day) (year)
Cemetery or crematory Prospect Hill
Location Washington D.C.
18. Funeral director L. Gasch's Sons
Address Hyattsville Md.
19. 9/3 19 45 Amanda L. Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-31 1945, at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 30 19 , to Aug 31 1945 and that I last saw h— alive on Aug 31 1945

Immediate cause of death Strangulation of bowel of hernia + gangrene of 4 feet of small intestine

Due to

Due to

Other conditions [illegible]

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE [illegible] M. D. or other
Address Hyattsville [illegible] Date signed 9-1-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (836)

CERTIFICATE OF DEATH

08214

Reg. Dist. No. 230

1. PLACE OF DEATH:

County: Pro Geo Co

City or town: Berwyn Hts Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Pro Geo Co

City or town: Berwyn Hts Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5618 Kenilworth rd

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: Mr. Jay G. Hunt

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Ollie A Hunt

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): March 9. 1870

8. AGE: Years: 75 | Months: | Days: | If less than one day: ...hrs. ...min.

9. Birthplace: Kansas (Town, county, and state)

10. Usual occupation: Clerk - Government

11. Industry or business: Retired

FATHER — 12. Name: Felix G. Hunt

FATHER — 13. Birthplace: N.C.

MOTHER — 14. Maiden name: unknown

MOTHER — 15. Birthplace: Illinois

16. Informant: Ollie A. Hunt

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 16 1945 (month) (day) (year)

Cemetery or crematory: Ft Lincoln

Location: Colmar Manor Md

18. Funeral director: F Gaeckis sons

Address: Hyattsville Md

19. August 14th 1945 (Date rec'd by registrar) John D. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 13 1945 at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 9 1945 to Aug 13 1945 and that I last saw him alive on August 7 1945

Immediate cause of death	DURATION
Cerebral thrombosis	3 mo.
Due to: General arteriosclerosis	10 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ... Injured at work?

23. SIGNATURE: L. W. Maler MD (M. D. or other)

Address: Riverdale, Md Date signed: Aug 13, 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-C)

CERTIFICATE OF DEATH

08215

Reg. Dist. No. 232

1. PLACE OF DEATH:
County: Prince Georges
City or town: Ritchie
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, institution, or street address where death occurred: Pr Geo. County Almshouse
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Pr. George
City or town: Ritchie
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Almshouse
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: John James

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	C.	Married

6.(b) Name of husband or wife: Maggie James
6.(c) If alive, give age: [illegible] years

7. Birth date of deceased (mo., day, yr.): 1878

8. AGE: Years: 67 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Boyd[illegible] County Va
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name:
13. Birthplace:

MOTHER
14. Maiden name: Mary Brooks
15. Birthplace:

16. Informant: Almshouse records
Address: Ritchie Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 14. 45.
(month) (day) (year)
Cemetery or crematory: Prince Geo. Co. Alms House
Location: Ritchie, Md.

18. Funeral director: Ritchie Bros.
Address: Upper Marlboro, Md.

19. Aug 14 1945 [signature] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 12 1945, at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1942, to Aug 12 1945
and that I last saw h.i. alive on Aug 10 1945

Immediate cause of death	DURATION
Chronic Hypertension	2
Due to: Nephritis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John J. Malonen M.D.
M. D. or other
Address: Cheverly - Hyattsville Date signed: Aug 13 '45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

68216

★ Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Silver Hill

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Permanent

Hospital, Institution, or street address where death occurred: Destruct Sand and Gravel Co

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Forest

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Robert Franklin James

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Martha James

6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): August 30, 1883

8. AGE: Years	Months	Days	If less than one day
61	11	20	...hrs. ...min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Steam Shovel Operator

11. Industry or business

FATHER — 12. Name: Joseph James

13. Birthplace: Virginia

MOTHER — 14. Maiden name: Smithers

15. Birthplace: Virginia

18. Informant: William H. James

Address: Bowie, Md.

17. (Burial, cremation, or removal. Which?) Date thereof: Aug 22 1945 (month) (day) (year)

Cemetery or crematory: Procter

Location: Spotsylvania Va.

18. Funeral director: Martin Gladden & Sons

Address: Bowie Md.

19. Received Aug 22 19 45 (Date rec'd by registrar) Mrs J.H. Yingling Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 20 1945, at 7:00 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ...19..., to ...19...

and that I last saw h... alive on ...19...

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to: Cardiovascular renal disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Deputy Medical Examiner M. D. or other

Address: Forestville Md. Date signed 8-22-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(18217)

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 1 month

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 941 - K. Street N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: –

3.(a) FULL NAME: LESKO, ELIZABETH

3.(b) Social Security Number: ?

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 12, 1920

8. AGE:

Years	Months	Days	If less than one day
24	11	8	hrs. min.

9. Birthplace: Mahanoy, Pennsylvania
(Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business:

FATHER
12. Name: John Lesko
13. Birthplace: Czechoslovakia

MOTHER
14. Maiden name: Veronica Oniffrey
15. Birthplace: Mahanoy, Pennsylvania

16. Informant: Decedent
Address:

17. Removal to (Burial, cremation, or removal. Which?) Date thereof: Aug 21, 1945 (month) (day) (year)

Cemetery or crematory:

Location: Mahanoy City, Pa

18. Funeral director: S. H. Hyle Co. F.D., Washington, D.C.

Address: 2901 14th St. N.W.

19. Aug 20 1945 (Date rec'd by registrar) Rowland S. Philips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 20 1945 at 10.45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/20 1945 to 8/20 1945 and that I last saw her alive on 8/20 1945

Immediate cause of death	DURATION
Tuberculosis, Pulmonary	7 Mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: 8/20/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr Hayes

18218

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Pro Geo Co
City or town: Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 weeks
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pro Geo Co
City or town: 5501 - 40 St Ave
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Hyattsville Md
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Cora H. Lewis

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widower

6.(b) Name of husband or wife: addison T Lewis
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 23, 1866

8. AGE: Years	Months	Days	If less than one day
79			hrs. min.

9. Birthplace: Ga (Town, county, and state)
10. Usual occupation: at Home
11. Industry or business:
FATHER 12. Name: Geo T walker
13. Birthplace: Ga
MOTHER 14. Maiden name: Emily Mason
15. Birthplace: Ga
16. Informant: Mr Lewis
Address: 5501 - 40th Place Hyattsville Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 20. 1945 (Month) (day) (year)
Cemetery or crematory: Gloucester
Location: Maryland
18. Funeral director: F Gracie's sons
Address: Hyattsville Md
19. Aug 18 1945 (Date rec'd by registrar) James Sevens Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 18, 1945, at 1230a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1944, to Aug 15 1945
and that I last saw h alive on Aug 1 1945

Immediate cause of death	DURATION
Cerebral hem	1 hr
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Jerman Hayes M. D. or other
Address: Hyattsville Md Date signed: 8-18-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08219

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 628 - A. St. N. E.
(If rural, give LOCATION)

2.(a) If veteran, name war: –

3.(a) FULL NAME: LYONS, MARY E.

3.(b) Social Security Number: –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: –

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): June 16, 1872

8. AGE: Years	Months	Days	If less than one day
73	1	25	____ hrs. ____ min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business:

FATHER
12. Name: Hugh Lyons
13. Birthplace: Philadelphia, Pennsylvania

MOTHER
14. Maiden name: Sara L. Harrison
15. Birthplace: Washington, D. C.

16. Informant: Decedent
Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof 8. 11. 45 (month) (day) (year)

Cemetery or crematory: to Washington, D. C.

Location:

18. Funeral director: J. Wm Lee's Sons

Address: 300-4th St NE

19. 8/11 (Date rec'd by registrar) 19 45 Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 10, 1945, at 45 p. m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 20, 1945, to Aug. 10, 1945 and that I last saw her alive on Aug. 10, 1945

	DURATION
Immediate cause of death: Tuberculosis pulmonary	11 mos.
Due to: (2)	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md., Date signed: Aug 10, 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-E)

CERTIFICATE OF DEATH

8220

Reg. Dist. No. 230

1. PLACE OF DEATH:
County: Pro Georges County
City or town: Beltsville Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Pro Geo County
City or town: Beltsville Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. --
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: William Mayo Marcus

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Lutie V Marcus
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 8, ~~1885~~ 1887

8. AGE: Years	Months	Days	If less than one day
57	-		hrs. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Postman
11. Industry or business: U. S. Gov't
FATHER 12. Name: John C. Marcus
FATHER 13. Birthplace: Virginia
MOTHER 14. Maiden name: Alberta Ternary
MOTHER 15. Birthplace: Virginia
16. Informant: Lutie V. Marcus
Address: Beltsville Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 11, 1945 (month) (day) (year)
Cemetery or crematory: Fort Lincoln Cemetery
Location: Colmar Manor Maryland
18. Funeral director: F. Gasch's Sons
Address: Hyattsville Maryland.
19. August 11th 1945 (Date rec'd by registrar) John D Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 10, 1945 19..... at 12.55 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 20 1940 to Aug 10 1945
and that I last saw him alive on Aug 10 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	10 yrs.
Due to:	
Due to:	
Other conditions: Laryngeal [illegible]	6 mo.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J M Warren M.D. M. D. or other
Address: Laurel, Md. Date signed: 8/10/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of age is shown on MLR No. G97 SEP 6 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

08221

CERTIFICATE OF DEATH

★ Reg. Dist. No. 234

1. PLACE OF DEATH:
County: Prince George County
City or town: Oxon Hill, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 Years Plus
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: 5410 LIVINGSTON ROAD, OXON HILL, MD.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 5410 LIVINGSTON ROAD, OXON HILL, MD.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: MRS. PIETRINA MISTRETTA

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

B.(b) Name of husband or wife: Mr. Salvatore Mistretta
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 28th, 1854

8. AGE: Years	Months	Days	If less than one day
91 ~~90~~			..... hrs. ..... min.

9. Birthplace: PALERMO, ITALY
(Town, county, and state)
10. Usual occupation: HOUSEWIFE
11. Industry or business

FATHER
12. Name: Pasquale Bottone
13. Birthplace: Italy

MOTHER
14. Maiden name: Catherina Bottone
15. Birthplace: Italy

16. Informant: Mr. Antonio Mistretta
Address: 1307 L'Enfant Square, S.E.

17. Burial (Burial, cremation, or removal. Which?) Date thereof August 22, 1945 (month) (day) (year)
Cemetery or crematory: Mount Olivet Cemetery
Location: WASHINGTON, D.C.
18. Funeral director: Martin W. Kyson & Co.
Address: 1300 N. STREET, NORTHWEST
19. Aug 21 1945 (Date received by registrar) Harold L. Odell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 20th, 1945 19 45, at 9:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1 19 45 to Aug. 20 19 45 and that I last saw h... alive on Aug. 20 19 45

Immediate cause of death	DURATION
Myocardial Failure	2 Days
Due to: Hypertension - Arteriosclerotic heart disease	4-5 Years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Phillip Grohman M.D. M. D. or other
Address: 2924 Wisconsin Ave. NW Date signed: 8/21/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (64-a)

CERTIFICATE OF DEATH

★ Reg. Diat. No. 08222 242

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

I. PLACE OF DEATH:

County: Prince Georges

City or town: Forestville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, institution, or street address where death occurred:
5824 - First Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Forestville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5824 - First
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Milton Theodore Mitchell

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Josephine Mitchell

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 13, 1907

8. AGE:	Years	Months	Days	If less than one day
	37	11	16	..... hrs. ..... min.

9. Birthplace: Mc Kendree, Md
(Town, county, and state)

10. Usual occupation: Machinist

11. Industry or business: U. S. Torpedo Plant

FATHER
12. Name: Charles W. Mitchell
13. Birthplace: Maryland

MOTHER
14. Maiden name: Eva E. Meredith
15. Birthplace: Maryland

16. Informant: Randolph Mitchell
Address: Forestville, Md.

17. Buried (Burial, cremation, or removal? Which?) Date thereof 9-7-45. (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Suitland, Md.

18. Funeral director: Ritchie Brothers

Address: Upper Marlboro, Md.

19. 8/31 19 45 (Date rec'd by registrar) Thos. S. Griffith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 29 19 45 at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Asphyxia	
Due to: Hanging	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of 8-29-45

Where did injury occur? Forestville (City or town) P.G. (County) Md. (State)

Injured at home, farm, industry, public place (where)? Garage at home

Means of injury: Hanging Injured at work? No

Deputy Medical Examiner

23. SIGNATURE: James D. [illegible] M. D. (Other)

Address: Forestville, Md. Date signed 8-29-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18a)

CERTIFICATE OF DEATH

0822 3 30

Reg. Dist. No. [illegible]

1. PLACE OF DEATH:

County: Prince George

City or town: Cheverly

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Cheverly (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Alexander Benjamin Morrison

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Elizabeth Jane Morrison

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 23 - 1862

8. AGE: Years	Months	Days	If less than one day
82	8	7	..... hrs. ..... min.

9. Birthplace: Scotland (Town, county, and state)

10. Usual occupation: Lumberman (Retired)

11. Industry or business

FATHER — 12. Name: Thomas Morrison

13. Birthplace: Scotland

MOTHER — 14. Maiden name: Margaret ?

15. Birthplace: Scotland

16. Informant: Robert Morrison

Address: 4640 Tennalon Place, Wash. D.C.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Aug. 30 - 1945 (month) (day) (year)

Cemetery or crematory: Washington D.C.

Location

16. Funeral director: Joseph F. Burke's Son

Address: 3004 - M St. N.W. Wash DC.

19. Aug 30 1945 (Date rec'd by registrar) John D. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 30 1945 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 22 1945 to Aug 30 1945 and that I last saw h- alive on Aug 30 1945

Immediate cause of death	DURATION
Bronchopneumonia	5 days
Due to Injury By Spine	
Died Dined in Fall	9 days
Due to	
Other conditions Arteriosclerosis	10 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide? Accident Date of Aug 22 '45

Where did injury occur? Mountrath P.G. Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Fell & injured Injured at work? No

23. SIGNATURE: J. M. Barrett M.D.

M. D. or other

Address: Laurel Md Date signed 8/30/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (184)

CERTIFICATE OF DEATH

18224

Reg. Dist. No. 232

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Prince George's
City or town Cheverly (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Transient
Hospital, Institution, or street address where death occurred: Meadowbrook Prince George Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Prince George
City or town Cheltenham (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Carolyn Roberta Myers

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 8, 1928

8. AGE: Years 16 | Months 11 | Days 2 | If less than one day ... hrs. ... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation

11. Industry or business At home

FATHER 12. Name Cecil Gideon Myers

13. Birthplace Virginia

MOTHER 14. Maiden name Telly Katherine Estes

15. Birthplace Maryland

16. Informant Cecil G. Myers

Address Cheltenham, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8 (month) 13 (day) 45 (year)

Cemetery or crematory Full Gospel Tabernacle

Location Cedarville Md

18. Funeral director Ritchie Bros

Address Upper Marlboro Md

19. Aug 13 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10 1945 at 5:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Hemorrhage	
Shock	
Due to Gun-shot wound	
of head	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide? Accident Date of 8-10-45

Where did injury occur? Cheltenham Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) In public place

Means of injury Shot with revolver Injured at work? No

23. SIGNATURE Deputy Medical Examiner M. D. or other

Address 7 Oestrella Md Date signed 8-12-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08225

Reg. Dist. No. 243

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 mos., 19 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 8 mos., 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Blue Plains
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Frank Nightingale

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife: Lucy King Nightingale
6.(c) If alive, give age: ?

7. Birth date of deceased (mo., day, yr.): May 11, 1878

8. AGE:	Years	Months	Days	If less than one day
	67	3	12	...hrs. ...min.

9. Birthplace: Washington, D. C.
(Town, county, and state)
10. Usual occupation: Jewelry Engraver
11. Industry or business:
FATHER 12. Name: Edward Nightingale
FATHER 13. Birthplace: Virginia
MOTHER 14. Maiden name: Louise Baker
MOTHER 15. Birthplace: Virginia
16. Informant: Decedent
Address:
17. (Burial, cremation, or removal. Which?) Removal Date thereof (month) (day) (year) Aug 25, 1945
Cemetery or crematory: 436-7th
Location: S.W. Washington, D.C.
18. Funeral director: K. J. Gattamelata
Address: 436 7th St. SW Washington DC
19. (Date rec'd by registrar) Aug 25 1945 Registrar: Rowland J. Phillips

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 25 1945, at 10:10 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 4, 1945, to Aug 23 1945
and that I last saw h... alive on Aug 23 1945.

	DURATION
Immediate cause of death: Pulmonary tuberculosis	3 yrs.
Due to: Genito urinary tuberculosis	7 mo.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed: 8-25-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B1a)

CERTIFICATE OF DEATH

08226

Reg. Diat. No. 245

1. PLACE OF DEATH:
County: Prince Geo. Co.
City or town: Riverdale, md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Leland mem. Hosp
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Newyork County:
City or town: Brooklyn, Newyork
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1492 Park Place,
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Benjamin Novick

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Rose Novick
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): -1894

8. AGE: Years: 54 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual occupation: Operator, Clothing factory

11. Industry or business: Brooklyn Newyork

FATHER
12. Name: David Novick
13. Birthplace: Russia

MOTHER
14. Maiden name: Unknown
15. Birthplace: Russia

16. Informant: Harry Novick,
Address: 4-B Plateau Pl. Beltsville, md

17. Buried (Burial, cremation, or removal. Which?) Date thereof: 8-6-45 (month) (day) (year)
Cemetery or crematory: Mt. Lebanon Cemetery
Location: Queens, Newyork

18. Funeral Director: Duvall Chambers Co
Address: Riverdale, md.

19. Aug. 6 1945 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 6 1945, at 3:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Acute Congestive heart failure	
Due to: Cardiovascular renal disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Deputy medical Examiner M. D. or other
Address: Prestly md Date signed: 8-6-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13a)

CERTIFICATE OF DEATH

68227

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince George's

City or town Mt Rainier

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 Years

Hospital, Institution, or street address where death occurred:

4207 - 28th Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Mt. Rainier

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4207 - 28th Street

(If rural, give LOCATION)

2.(a) If veteran, name war W. W. #1

3. (a) FULL NAME Francis Aloysius O'Brien

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Martha M. O'Brien

6.(c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Aug 26, 1888

8. AGE: Years	Months	Days	If less than one day
56 ~~55~~	11	21	hrs. min.

9. Birthplace Washington D.C.
(Town, county, and state)

10. Usual occupation Painter

11. Industry or business

FATHER 12. Name Francis Aloysius O'Brien

FATHER 13. Birthplace Washington D.C.

MOTHER 14. Maiden name Anna Condon

MOTHER 15. Birthplace Ireland

16. Informant Aloysius J. O'Brien

Address 4209 Farragut Street Hyattsville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 21, 1945 (month) (day) (year)

Cemetery or crematory Arlington Cemetery

Location Arlington Va

18. Funeral director E. Leach Sons

Address Hyattsville Md.

19. Aug 20 1945 James Seery

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 17 1945 at 4:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

Deputy medical examiner

23. SIGNATURE James J. Boyd M. D. or other

Address Hyattsville Md. Date signed 8-19-41

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

08228

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

★ Reg. Diat. No. 245

1. PLACE OF DEATH:
County Prince Georges
City or town Hollywood
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, Institution, or street address where death occurred:
9509 - 50th Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Hollywood
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9509 - 50th Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Lloyd George Parker

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife Elizabeth Parker
6.(c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Aug 21 1900

8. AGE: Years 45 | Months 0 | Days 6 | If less than one day ..... hrs. ..... min.

9. Birthplace Michigan (Town, county, and state)
10. Usual occupation Policeman
11. Industry or business District of Columbia
FATHER 12. Name Edward Parker
FATHER 13. Birthplace Unknown
MOTHER 14. Maiden name Lula Crowley
MOTHER 15. Birthplace Unknown
16. Informant Mrs. Elizabeth Parker
Address Hollywood, Md.
17. Removal (Burial, cremation, or removal. Which?) Date thereof Aug 27 1945 (month) (day) (year)
Cemetery or crematory Washington D.C.
Location 2901 - 14th St. N.W.
18. Funeral director L.P. Hines Co.
Address 2901 - 14th St. N.W.
19. Aug 27 1945 (Date rec'd by registrar) James Devey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27 1945 at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to Cardiovascular Renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Deputy medical Examiner M. D. or other
Address Forestville Md. Date signed 8-27-45

M

1

2

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1642)

CERTIFICATE OF DEATH

(0822?)

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince George's
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, institution, or street address where death occurred:
4231 Oglethorpe
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4231 Oglethorpe
(If rural, give LOCATION)
2.(a) If veteran, name war: World War # 1

3. (a) FULL NAME: Frank Pavlat

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Glady Pavlat
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 16, 1893

8. AGE: Years	Months	Days	If less than one day
52	3	0	hrs. min.

9. Birthplace: Lodgepole, Neb. (Town, county, and state)
10. Usual occupation: Clerk
11. Industry or business: Post Office

FATHER
12. Name: John Pavlat
13. Birthplace: Bohemia

MOTHER
14. Maiden name: May ------
15. Birthplace: Bohemia

16. Informant: Mrs. Gladys Pavlat
Address: Hyattsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 20, 1945 (month) (day) (year)
Cemetery or crematory: Arlington Cemetery
Location: Arlington, Va

18. Funeral director: F. Gasch & Son
Address: Hyattsville Md.

19. Aug 20 1945 (Date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 16 1945, at 2:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Hemorrhage and shock	
Due to: Gun shot wound of the head	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of: 8/16/45
Where did injury occur? Hyattsville (City or town) P. G. (County) Md. (State)
Injured at home, farm, industry, public place (where?): Home
Means of injury: Gun shot Injured at work? No

23. SIGNATURE: Deputy Medical Examiner James S. Ford M.D. or other
Address: Forestville, Md. Date signed: 8/17/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(8230)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince Georges County
City or town: Clinton Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Clinton
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME: Rosalee Bouie Penn

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife: William E. Penn
6.(c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.): May 11 1867

8. AGE: Years 78 | Months — | Days | If less than one day ... hrs. ... min.

9. Birthplace: Rockville Md
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At Home

FATHER
12. Name: David Bouie
13. Birthplace: Rockville Md

MOTHER
14. Maiden name: Sarah Alice Rankeberger
15. Birthplace: Fredrick, Md

16. Informant: Mrs Allen Penn
Address: Clinton Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-27-45 (month) (day) (year)
Cemetery or crematory: Rockville Union
Location: Rockville, Md

18. Funeral director: Wm Reuben Pumphrey
Address: Rockville, Md

19. 8/25 (Date rec'd by registrar) 1945 Thos J Griffith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 24 1945, at 3 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1945 to Aug 24 1945 and that I last saw h. alive on Aug 23 1945

Immediate cause of death	DURATION
Acute Myocardial Decompensation	3 hours
Due to: Chronic endocarditis and Chronic myocarditis	unknown unknown
Due to: unknown	
Other conditions: Generalized Arteriosclerosis	unknown

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE: Paul Van Natta M. D. or other
Address: Washington 19 DC Date signed: Aug 24 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31a)

CERTIFICATE OF DEATH

8231

★ Reg. Dist. No. 234-105

1. PLACE OF DEATH:

County Prince Georges

City or town Camp Springs

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, institution, or street address where death occurred:

5500 Auth Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Camp Springs

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5500 Auth Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Eugene Proctor

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Colored	Married

6.(b) Name of husband or wife Sarah C. Proctor

6.(c) If alive, give age 82 years

7. Birth date of deceased (mo., day, yr.) June 15, 1861

8. AGE: Years 84 | Months 1 | Days 25 | If less than one day ..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Charles Proctor

13. Birthplace Maryland

MOTHER 14. Maiden name Polly Butler

15. Birthplace Maryland

16. Informant Mary A. Proctor

Address Camp Springs, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 13 45 (month) (day) (year)

Cemetery or crematory St Peters

Location Waldorf Md

18. Funeral director Hewitt & Ryon

Address Waldorf Md

19. Aug 11 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 10 1945, at 8 40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 1944, to Aug 10 1945

and that I last saw h... alive on Aug 8 1944

Immediate cause of death	DURATION
Uremia	
Due to Cardio vascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner

23. SIGNATURE James A. Floyd M. D. or other

Address Forestville Md Date Signed 8-10-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-2)

CERTIFICATE OF DEATH

18232

Reg. Dist. No. 245

1. PLACE OF DEATH:
County Prince George
City or town Riverdale
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Eugene Leland Memorial Hospital
Stay in hospital or inst. (yrs., or mos., or days) 4 days 13 hrs. 20 min.
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Laurel Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR ✓

3. (a) FULL NAME Norman Dwight Quigley

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

8 (b) Name of husband or wife —

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) August 27th 1945

8. AGE: Years | Months | Days: 4 | If less than one day: 13 hrs. 20 min.

9. Birthplace Riverdale, Md. Prince George Co.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name George Dewitte Quigley
13. Birthplace Penna.

MOTHER
14. Maiden name Mildred Lillian Brown
15. Birthplace Penna.

16. Informant Mother's Chart.
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 2 1945 (month) (day) (year)
Cemetery or crematory Nat. Capital Memorial Park
Location Muirkirk, Maryland

18. Funeral director DeWitt Donaldson
Address Laurel, Maryland

19. Sept. 1 19 45 (Date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 31 19 45, at 11:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 24 19 45, to Aug 31 19 45, and that I last saw him alive on Aug 31 19 45.

	DURATION
Immediate cause of death: Congenital malformations brain, Ventricular (157-2)	4 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Robert S. McGinnis M.D.
M. D. or other
Address Laurel Md. Date signed 9/1/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08233

★ Reg. Diat. No. 231

1. PLACE OF DEATH:
County: Prince Georges
City or town: Cheverly Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Transient
Hospital, institution, or street address where death occurred:
B. & O. R.R. Tracks
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Prince Geo Co.
City or town: Cheverly Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Camp 375.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Faustino Vazquez Ramirez

3.(b) Social Security Number: 724-26-5675

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 14, 1912

8. AGE: Years	Months	Days	If less than one day
33	3	6	hrs. min.

9. Birthplace: Elta OAX Mexico
(Town, county, and state)
10. Usual occupation: trackman
11. Industry or business: Penna R.R

FATHER
12. Name: Macario Vazquez
13. Birthplace: Mexico

MOTHER
14. Maiden name: Manuela Ramirez
15. Birthplace: Mexico

16. Informant: John Esperonza
Address: Cheverly Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 22, 1945 (month) (day) (year)
Cemetery or crematory: Geo Washington
Location: Berwyn Md
18. Funeral director: F. Gaschi Sons
Address: Hyattsville Md.

19. 8/21/45 (Date rec'd by registrar)
Amanda Downey, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 22 19 45 at 6 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Multiple crushing injuries to body	
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? Accident Date of 8-20-45
Where did injury occur? Landover P.G. Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): B.R.R. track
Means of injury: Struck by train Injured at work? Yes
Deputy medical Examiner
23. SIGNATURE: M. D. or other
Address: Hyattsville Md Date signed: 8-21-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

08234

Reg. Dist. No. 231

1. PLACE OF DEATH
County Pr. Geore
City or town Landover Hills, md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 mo
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State md County Pr. Geo
City or town Landover Hills, md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4218-70th ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Catherine Fleiner Redding

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife James Redding
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 27-1890

8. AGE: Years 54 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Pa (Town, county, and state)

10. Usual occupation Telephone operator

11. Industry or business P.R.R. Pgh. Pa

FATHER 12. Name James Murry
13. Birthplace Pa

MOTHER 14. Maiden name Catherine Walsh
15. Birthplace Pa

16. Informant Patricia Nicholson
Address 4218-70th Ave. Land Over Hills md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-20-45 (month) (day) (year)

Cemetery or crematory St. Georges Cemetery
Location Carrick-Pittsburg, Pa

18. Funeral director Mow Chamberlain Co
Address Riverdale, md

19. 8/20 1945 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-20 1945 at 7a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15, 1945 to Aug. 20, 1945
and that I last saw her alive on Aug. 8 1945

Immediate cause of death	DURATION
Carcinoma of Stomach	
Due to Carcinoma of stomach with metastasis to liver	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Walter Hoff M. D. or other
Address Hattiesburg Miss Date signed 8-20-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

18235

Reg. Dist. No. 23 2

1. PLACE OF DEATH:
County: Prince Georges
City or town: Croom
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Croom
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: Frederick Leon Richardson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	single

6.(b) Name of husband or wife: —
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Apr. 27-45.

8. AGE: Years: — Months: 4 Days: 1 If less than one day: ____ hrs. ____ min.

9. Birthplace: Croom, Md.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER
12. Name: Joseph Boswell
13. Birthplace: Pr. Geo. Co., Md.

MOTHER
14. Maiden name: Ruth Richardson
15. Birthplace: Pr. Geo. Co., Md.

16. Informant: Joseph Boswell
Address: Croom, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 30-45 (month) (day) (year)
Cemetery or crematory: Mt. Carmel
Location: Upper Marlboro, Md.

18. Funeral director: Pilkie Bros.
Address: Upper Marlboro, Md.

19. Aug 30 1945 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 28 1945 at 6:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 25 1945 to Aug 27 1945 and that I last saw alive on Aug 27 1945

Immediate cause of death	DURATION
Cholera Infantum	Week
Due to	
Due to	
Other conditions: Secondary Anemia	2 wks

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.:
Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James C. Spencer M. D. or other
Address: Upper Marlboro Date signed: 8-29-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 27-C

CERTIFICATE OF DEATH

08236

★ Reg. Dist. No. 242

1. PLACE OF DEATH:

County: Prince Georges

City or town: Fairmount Heights Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs

Hospital, Institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: P.G. Co.

City or town: Fairmount Heights

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1000 - 62nd Pl.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Howard Robertson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	single

6.(b) Name of husband or wife: —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 9 1943

8. AGE:

Years	Months	Days	If less than one day
2	6	12	..... hrs. ..... min.

9. Birthplace: Laurel Miss. - Town at Freedmans Home (Town, county, and state)

10. Usual occupation: none

11. Industry or business: —

FATHER

12. Name: unknown

13. Birthplace: unknown

MOTHER

14. Maiden name: Estelle Gorman

15. Birthplace: S.C.

16. Informant: Johnie Gorman

Address: Fairmount Heights Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 23. 1945 (month) (day) (year)

Cemetery or crematory: Woodlawn Cem.

Location: Washington D.C.

18. Funeral director: J. B. Johnson

Address: Annapolis, Md.

19. 8-22- 1945 (Date rec'd by registrar) Irene A. Conner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 21 1945 at 3.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 20 1945, to Aug 21 1945

and that I last saw h... alive on Aug 21 1945

Immediate cause of death	DURATION
Dysentery	48 hrs
Due to: Intestinal	
Due to: unknown	
Other conditions: — none	

(Include pregnancy within 3 months of death)

Major findings of operations: — none

Date of op. —

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Wm Brady Jr M.D. M. D. or other

Address: Fort Pleasant Md Date signed: Aug 21/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

08237

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince Georges
City or town: Hyattsville 9 md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year.
Hospital, institution, or street address where death occurred: 4908-43rd ave E
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4908-43rd ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: William Edward Rollins

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Zetta Ellen Rollins
6.(c) If alive, give age: 46 years
7. Birth date of deceased (mo., day, yr.): Dec 6 1863

8. AGE: Years: 82 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Wash D C
(Town, county, and state)
10. Usual occupation: Engineer
11. Industry or business: Goverment office building

FATHER
12. Name: Edward P Rollins
13. Birthplace:

MOTHER
14. Maiden name: Elizabeth Cox
15. Birthplace: Wash D C

16. Informant: Mrs Zetta Rollins
Address: 4908-43rd ave Hyattsville Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Aug 20 1945 (month) (day) (year)
Cemetery or crematory: Washington D C
Location:

18. Funeral director: The S H Hines Co.
Address: 2901-14th St N W

19. Aug 18 1945 (Date rec'd by registrar) James Devey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 18 19 45 at 2 35 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 37 to Aug 18 19 45
and that I last saw him alive on Aug 11 19 45

Immediate cause of death	DURATION
Uremia	1 hr.
Due to: General Arteriosclerosis	10 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: L W Mahin M D
M. D. or other
Address: Riverdale Md Date signed: 8-18-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08238

★ Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: Glenn Dale - Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 Yrs.
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium, Glenn Dale
How long in hospital or institution? 4 Yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1345 Irving St. N.E.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: James W. Roy

3.(b) Social Security Number: 578-12-2572

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col.	Married

6.(b) Name of husband or wife: Mrs. Cora L. Roy
8.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 3-10-1915

8. AGE: Years	Months	Days	If less than one day
30	5	21	hrs. min.

9. Birthplace: Washington, D.C.
(Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business:
FATHER 12. Name: Unknown
13. Birthplace: -
MOTHER 14. Maiden name: Della Roy
15. Birthplace: Virginia
16. Informant: deceased
Address:
17. Removal (Burial, cremation, or removal. Which?) Date thereof: Sept 1st 1945 (month) (day) (year)
Cemetery or crematory:
Location: To Washington D.C.
18. Funeral director: John T. Rhines & Co
Address: 901-3rd St. S.W.
19. Aug 31 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8/31 1945 at 8:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/23 1941 to 8/31 1945 and that I last saw h.i.m. alive on 8/31 1945

Immediate cause of death	DURATION
Pulmonary tuberculosis	4 yrs.
Due to:	
Due to:	
Other conditions: Tuberculosis rt. Elbow.	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale Md. Date signed: 8/31/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

08239

★ Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince Georges

City or town: Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, institution, or street address where death occurred: Leland Memorial Hospital

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Charles

City or town: Waldorf

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Route #1

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Mickie Ann Shinnault

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
fe	white	widowed

6.(b) Name of husband or wife: James Birum Shinnault 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 17, 1868

8. AGE: Years	Months	Days	If less than one day
77	1	16	hrs. min.

9. Birthplace: North Carolina (Town, county, and state)

10. Usual occupation: retired

11. Industry or business

FATHER 12. Name: John Johnson

FATHER 13. Birthplace: unknown

MOTHER 14. Maiden name: Mary ?

MOTHER 15. Birthplace: unknown

16. Informant: Hospital Records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 4, 1945 (month) (day) (year)

Cemetery or crematory: St Pauls

Location: waldorf Md

18. Funeral director: Hunt & Ryan

Address: waldorf Maryland

19. Aug 2 1945 (Date rec'd by registrar) James Beyer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 1 19 45 at 2 55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 26 19 45 to Aug 1 19 45

and that I last saw h alive on Aug 1 19 45

Immediate cause of death	DURATION
Fractured Right Hip	5 days
Due to	
Due to	
Other conditions: Myocardial Failure	4 days

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of July 26 1945

Where did injury occur? Waldorf (City or town) Charles (County) Md (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: Fell in room Injured at work?

23. SIGNATURE: L W Malin M D (M. D. or other)

Address: Riverdale Md Date signed: 8-1-45

VS A15

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr Jame Boyd Prince Georges County Medical examiner investigated and asked me to sign the certificate

L C Malone M D

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08240

★ Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Fairfax
City or town Alexandria
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, Institution, or street address where death occurred: Sacred Heart Home, 5801 Duke St.
How long in hospital or institution? 2 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Va County Fairfax Va
City or town Falls Church
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME Nellie Hamilton Smith

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 2nd 1851

8. AGE: Years	Months	Days	If less than one day
94	—	27	hrs. min.

9. Birthplace New London Connecticut (Town, county, and state)
10. Usual occupation Retired Government Clerk
11. Industry or business Smithsonian Institution
FATHER 12. Name William Mowry Smith
13. Birthplace Middletown, Conn.
MOTHER 14. Maiden name Jane Rebecca Hamilton
15. Birthplace New London Conn
16. Informant Nellie Hamilton Smith
Address Personal History
17. Removal (Burial, cremation, or removal. Which?) Date thereof aug 30 1945 (month) (day) (year)
Cemetery or crematory Va
Location Falls Church
18. Funeral director F Gascho Sons
Address Fredericksburg Va
19. Aug 30 1945 (Date rec'd by registrar) James Beaver Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29th 1945, at 10:15 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1943, to August 29th 1945
and that I last saw her alive on August 29th 1945

Immediate cause of death	DURATION
General Debility of Age	2 years
Due to Advanced Age	
Due to	
Other conditions No organic disease	

(Include pregnancy within 3 months of death)
Major findings of operations No operations Date of op.
Autopsy results None made
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide None Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) No
Means of injury Injured at work?

23. SIGNATURE Ira N Dennison M.D. M. D. or other
Address 2430-20th NW Wash DC Date signed 8/29/1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

08241

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 5 mos., 15 days

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 1 yr., 5 mos., 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1615 Kenyon Street N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: –

3.(a) FULL NAME: Helen Ester Springston

3.(b) Social Security Number: –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Perry H. Springston

6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): March 3, 1895

8. AGE: Years	Months	Days	If less than one day
50	5	18	...hrs. ...min.

9. Birthplace: DeWitt, Iowa
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Elmer E. Forbes
13. Birthplace: DeWitt, Iowa

MOTHER
14. Maiden name: Nellie E. Calnan
15. Birthplace: Clinton, Iowa

16. Informant: Decedent.
Address:

17. Removal to (Burial, cremation, or removal. Which?) Date thereof: Aug 21 1945 (month) (day) (year)

Cemetery or crematory:

Location: Washington, D.C.

18. Funeral director: S. H. Hines Co. F.D.

Address: 2401-14th St. N. W. Wash. D.C.

19. Aug. 21, 1945 (Date rec'd by registrar) Rowland S. Pilkington Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 21, 1945, at 4:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 6, 1944 to Aug. 21 1945 and that I last saw h.. alive on Aug 21, 1945

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 2 1/2 yrs

Due to: Carcinoma of the stomach — DURATION: 6 1/2 mo

Due to: — DURATION:

Other conditions: — DURATION:

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Linucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: Aug 24, 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-E)

CERTIFICATE OF DEATH

18242

★ Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince George's

City or town (rural) Glenn Dale Sanatorium

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo., 14 days

Hospital, institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution? 1 mo., 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. County

City or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1239 - 34th St. N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war –

3. (a) FULL NAME HOLBROOK STAMBAUGH

3. (b) Social Security Number ?

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Virgie Stambaugh

6.(c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) April 8, 1902

8. AGE: Years	Months	Days	If less than one day
43	4	8	....hrs. ....min.

9. Birthplace Paintsville, Kentucky (Town, county, and state)

10. Usual occupation Machinist Helper

11. Industry or business

FATHER 12. Name Laffayette Stambaugh

13. Birthplace Kentucky

MOTHER 14. Maiden name Sarah Murphy

15. Birthplace Kentucky

16. Informant Decedent

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof Aug. 16, 1945 (month) (day) (year)

Cemetery or crematory

Location Washington D.C.

18. Funeral director W.W. Chambers. Per Hurt.

Address 3072 M. N.W Wash DC

19. Aug. 16 19 45 Rowland S. Philips (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 16 19 45 at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JULY 2 19 45, to AUG. 16 19 45

and that I last saw him alive on AUG 16 19 45

Immediate cause of death	DURATION
PULMONARY TUBERCULOSIS	2 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Daniel Leo Finucane M.D.

M. D. or other

Address Glenn Dale, Md. Date signed 8/16/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

18243

★ Reg. Dist. No. 245

1. PLACE OF DEATH:
County Prince George
City or town Brentwood, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Brentwood Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3722 - Shepherd street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Ernest L. Steele

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of husband or wife Marie L. Steele (nee Grinstead) 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 1st. 1892

8. AGE: Years	Months	Days	If less than one day
53			..... hrs. ..... min.

9. Birthplace Iowa (Town, county, and state)
10. Usual occupation Mailer
11. Industry or business Mercury Press

FATHER
12. Name James Steele
13. Birthplace Iowa

MOTHER
14. Maiden name Mabel Owens
15. Birthplace Iowa

16. Informant Marie L. Steele
Address 3722 - Shepherd st. Brentwood Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 4th/45 (month) (day) (year)
Cemetery or crematory Fort Lincoln
Location Bladensburg Rd. Md. dist Line

18. Funeral director Wm. J. Bradley
Address 3200 - R.I. Ave. Mt. Rainier Md.

19. August 4 19 45 James Sevey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 2 19 45, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2 19 45 to August 2 19 45 and that I last saw h.im alive on July 27 19 45

Immediate cause of death	DURATION
Cardiac failure	
Hypertension Cereb. vascular disease	6 Months
Due to	
I first saw this man	
Due to July 20th. Dyspnea had been	
Other conditions Coffee to st.	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. B. Glenn M. D. or other
Address 2015 - Ave H. Date signed 8. 2. 45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21218)

CERTIFICATE OF DEATH

08244

Reg. Dist. No. 232

1. PLACE OF DEATH:

County: Prince Georges

City or town: Upper Marlboro, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Entire life years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Upper Marlboro, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Patuxent Route 2, Clairhill

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Robert Bruce Swanson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Jessie M. Swanson

6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): January 17, 1900

8. AGE:

Years	Months	Days	If less than one day
45	6	14	20 hrs. ... min.

9. Birthplace: Argyle, Mims (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farmer

FATHER 12. Name: George Ferguson Swanson

13. Birthplace: Scotland

MOTHER 14. Maiden name: Elizabeth Gordon

15. Birthplace: Scotland

16. Informant: Jessie M. Swanson

17. Burial (Burial, cremation, or removal): Date thereof: Aug. 4-45 (month) (day) (year)

Cemetery or crematory: Washington National

Location: Suitland, Md.

18. Funeral director: Gude Bros.

Address: Upper Marlboro, Md.

19. Aug 3rd 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 1. 1945 at 8:20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1, 1945 to Aug. 1, 1945 and that I last saw h... alive on July 29, 1945

Immediate cause of death:	DURATION
Cerebral Hemorrhage	3 days
Due to:	
Due to:	
Other conditions: Cirrhosis of liver alcoholic	Two years

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: R. Appgar, M.D. M. D. or other

Address: Upper Marlboro, Md. Date signed: Aug. 1, 45

Death Certificate Please Lot 493

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

18245

Reg. Diat. No. 232

1. PLACE OF DEATH:
County Prince Georges
City or town Rosamville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 21 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Rosamville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Nellie Taylor

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Alfred Taylor
6.(c) If alive, give age 67 years
7. Birth date of deceased (mo., day, yr.) Sept 21, 1878

8. AGE: Years 66 | Months 10 | Days 15 | If less than one day ... hrs. ... min.

9. Birthplace Holland (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Own Home

MOTHER FATHER
12. Name Peter Van Astem Budgil
13. Birthplace Holland

MOTHER
14. Maiden name Cora
15. Birthplace Holland

18. Informant Alfred W. Taylor
Address Rosamville Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 9. 45. (month) (day) (year)
Cemetery or crematory Chelsham Methodist
Location Chelsham, Md.
18. Funeral director Tolson Brothers
Address upper Marlboro, Md.
19. Aug 9 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 6 1945 at 5:20 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
acute Congestive heart failure	
Due to Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James T. Lamb Deputy medical Examiner
M. D. or other
Address Forestville Md Date signed 8-7-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

08246

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (176-e)

CERTIFICATE OF DEATH

Reg. Diat. No. 245

M

1

T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince Georges

City or town: College Park Tramwell

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Route #1

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Fort Meade

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: World War II

3.(a) FULL NAME: Arthur L. Teal

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Genevieve Teal

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 31, 1906

8. AGE: Years: 38 Months: 9 Days: 26 If less than one day: hrs. min.

9. Birthplace: Castleton, Wisconsin (Town, county, and state)

10. Usual occupation: Staff Sargeant

11. Industry or business: United States Army

FATHER

12. Name: Eugene Teal

13. Birthplace: Castleton, Wisconsin

MOTHER

14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: A. G. O. - U. S. Army

Address: Washington, D.C.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Aug 26, 1945 (month) (day) (year)

Cemetery or crematory: Walter Reid Hospital

Location: Washington, D.C.

18. Funeral director: F. Gaschis Sons

Address: Hyattsville, Md.

19. Aug 26 1945 James Devery (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 26 1945 at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Compression of Spinal cord	
Due to Fracture and dislocation 3rd	6th
Due to Cervical vertebrae	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 8-26-45

Where did injury occur? College Park (City or town) Prince Georges (County) Md. (State)

Injured at home, farm, industry, public place (where?) Route #1

Means of injury: Pedestrian struck by Car Injured at work?

23. SIGNATURE: [illegible] M. D. or other

Deputy medical Examiner

Address: Forestville Md. Date signed 8-26-45

5

Evidence for addition of place of death is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

08247

FILE No. G 97 AUG 31 1945

Reg. Dist. No. 142

1. PLACE OF DEATH:
County Prince Georges
6500 Sherriff Road
City or town Maryland - Fairmount Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
6500 Sherriff Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State County
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Percilla Thomas

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Colored	Widow

6.(b) Name of husband or wife Unknown
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years 56 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Arlington Va. (Town, county, and state)
10. Usual occupation Domestic
11. Industry or business
12. FATHER Name Willis Thomas
13. Birthplace Va
14. MOTHER Maiden name Percilla Fleet
15. Birthplace Va
16. Informant Pauline Martin
Address 6500 Sheriff Road
17. (Burial, cremation, or removal. Which?) Date thereof 8-9-1945 (month) (day) (year)
Cemetery or crematory Payne
Location Washington, D.C.
18. Funeral director Cuthlin L. Rollins
Address 4339 - Hunt Pl. N.E.
19. Aug. 8 — 19 45 (Date rec'd by registrar) Gene A. Downes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 6 19 45 at 6 30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 6 19 45 to Aug 6 19 45 and that I last saw h[illegible] alive on 19
Immediate cause of death — Hypostatic Pneumonia — 4 days
Due to (Arteriosclerotic Dementia) (Senile Dementia) — 1 yr.
Due to Generalized Arteriosclerosis. — ?
Other conditions Malnutrition — ?
Dehydration.
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Robert R. Nelson, MD M. D. or other
Address 811 Grant St. NE Date signed 8/6/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(1) MARGIN RESERVED FOR BINDING

VS A15

Evidence for change of age is shown on

08248

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

STATE No. G 97 SEP 6 1945

★ Reg. Diat. No. 245

1. PLACE OF DEATH:
County Pr. George
City or town Hyattsville md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State md County Pr. Geo
City or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4409 Madison St
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Frances Howard Walters

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6.(b) Name of husband or wife
B.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 4- 1855

8. AGE: Years	Months	Days	If less than one day
89	9-0		hrs. min.

9. Birthplace Washington N. Car
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Thomas Clark
13. Birthplace N. Car

MOTHER 14. Maiden name Frances H. Clark
15. Birthplace N. Car

16. Informant Frances Raley
Address 4409 Madison St. Hyattsville, md

17. Burial Date thereof 8-29-45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Washington N. Car
Location Beaufort Co.
18. Funeral director W W Chambers Co
Address Riverdale md
19. August 29, 19 45 James Sevey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-28- 1945 at 750 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-4-45 19 to 8-28 19 45
and that I last saw h. alive on 8-27-45 19

Immediate cause of death	DURATION
Trauma	5 days
Due to Cardio-vascular renal disease	18 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John P. Clum M.D.
M. D. or other
Address Hyattsville Md Date signed 8-29-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

08249

Reg. Dist. No. 230

1. PLACE OF DEATH:

County: Prince George Cty.

City or town: Muirkirk

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Prince George

City or town: Muirkirk

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME ETRULIA WEEMS

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
7	Colored	Widowed

6.(b) Name of husband or wife: Augustus Weems

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): July 26, 1888

8. AGE: Years: 57 | Months: | Days: | If less than one day: ____ hrs. ____ min.

9. Birthplace: Muirkirk, Prince Geo. Cty, Md.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: Nicholas Harrison
13. Birthplace: Md.

MOTHER
14. Maiden name: Louise Hebron
15. Birthplace: Md.

16. Informant: Rose Harrison
Address: Muirkirk Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 25 / 45
(Month) (day) (year)

Cemetery or crematory: Queen's Chapel Cem.

Location: Muirkirk, Md.

18. Funeral director: J. B. Thompson

Address: Annapolis Md.

19. Aug 24 1945 (Date rec'd by registrar) John D. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 25 19 45, at ____ M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 8 19 45 to Aug 25 19 45 P.M.

and that I last saw her alive on Aug 21 19 45

Immediate cause of death	DURATION
Chronic Myocarditis	2
Arteriosclerosis	
Due to: Chronic Interstitial Nephritis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Laurel Date signed Aug 28 45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 51-E

CERTIFICATE OF DEATH

08250

Reg. Dist. No. 232

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Prince Georges

City or town Leland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Leland
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Charles Windsor

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widower

8.(b) Name of husband or wife Mary L. Windsor

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 26, 1877

8. AGE: Years 68 | Months 0 | Days 22 | If less than one day ..... hrs. ..... min.

9. Birthplace Prince Georges Co., Md
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace Unknown

MOTHER 14. Maiden name Unknown

15. Birthplace Unknown

16. Informant John Milton Windsor

Address Leland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 21-45. (month) (day) (year)

Cemetery or crematory Mt. Carmel

Location Upper Marlboro, Md.

18. Funeral director Tolson Bros.

Address Upper Marlboro, Md.

19. Aug 20 1945 (Date rec'd by registrar) R. Lee Pratt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 18 1945, at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 1944, to Aug 18 1945

and that I last saw h... alive on Aug 16 1945

Immediate cause of death ..... DURATION

Exhaustion

Due to Carcinomas Hepatitis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James J. Bond M. D. or other

Address Upper Marlboro Md Date signed 8-22-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

08251

Reg. Dist. No. 233

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince Georges
City or town: Croom
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Prince George Co
City or town: Croom
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary Elizabeth Vondson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: John Vondson
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 17 - 1855

8. AGE: Years	Months	Days	If less than one day
90	4	28	..... hrs. ..... min.

9. Birthplace: Baden, Md (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: at Home
12. FATHER — Name: Don't Know
13. FATHER — Birthplace: Don't Know
14. MOTHER — Maiden name: Mary Eliz. Langley
15. MOTHER — Birthplace: Don't Know
16. Informant: Andrew Vondson
Address: Croom. Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 16 - 1945 (month) (day) (year)
Cemetery or crematory: St. Pauls
Location: Baden, Md. Pr. Geo. Co.
18. Funeral director: Ritchie Bros.
Address: Upper Marlboro, Md.
19. Aug 15 1945 (Date rec'd by registrar) James B Naylor Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 14 1945, at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 6 1945 to Aug 14 1945 and that I last saw ☐ alive on August 6 1945

Immediate cause of death	DURATION
Arteriosclerosis	6 yrs
Cerebral Hemorrhage	3 days
Due to: Arteriosclerosis	6 yrs
Due to: Age	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: John E Somers M.D
M. D. or other
Address: Brandywine, Md Date signed: 8/14/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (163-11)

CERTIFICATE OF DEATH

18252

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince Georges

City or town Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? transient

Hospital, Institution, or street address where death occurred:

5514 Baltimore Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. Annapolis Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Albert Wolf

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife Mary A. Wolf

6.(c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) June 1, 1904

8. AGE: Years 41 | Months 2 | Days 11 | If less than one day ..... hrs. ..... min.

9. Birthplace Germany (Town, county, and state)

10. Usual occupation merchant

11. Industry or business automobile

FATHER 12. Name unknown

13. Birthplace Germany

MOTHER 14. Maiden name unknown

15. Birthplace Germany

16. Informant Mary A. Wolf

Address Annapolis Rd, Hyattsville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 15, 1945 (month) (day) (year)

Cemetery or crematory Ft Lincoln

Location Colmar Manor Md

18. Funeral director F Gaeche Sons

Address Hyattsville Md

19. Aug 15 1945 (Date rec'd by registrar) James Beverz Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12 1945 at 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
(a) Asphyxia	
Due to (b) Acute Carbon Monoxide	
Poisoning	
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 8-12-45

Where did injury occur? Hyattsville Prince Georges Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) State Highway

Means of injury Carbon Monoxide Poisoning Auto Exhaust

23. SIGNATURE Deputy Medical Examiner M. D. or other

Address Prestwould Date signed 8-14-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08253

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 2 mos., 22 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 1 yr., 2 mos., 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 613 Acker Place N. E.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Young, Johnnie

3.(b) Social Security Number: 249-26-1509

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	Married

6.(b) Name of husband or wife: Rosie Young

6.(c) If alive, give age: 24 years

7. Birth date of deceased (mo., day, yr.): March 2, 1912

8. AGE: Years	Months	Days	If less than one day
33	5	-	hrs. min.

9. Birthplace: Lawrence, South Carolina
(Town, county, and state)

10. Usual occupation: Fireman

11. Industry or business:

FATHER
12. Name: Alfred Young
13. Birthplace: South Carolina

MOTHER
14. Maiden name: Emma Campb
15. Birthplace: South Carolina

16. Informant: Decedent
Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Aug 2 1945 (month) (day) (year)

Cemetery or crematory:

Location: Washington, D.C.

18. Funeral director: Frazier Funeral Co

Address: 389 - R.I. ave NW

19. Aug 2 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 2 1945 at 7:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-12 1945 to 8-2 1945

and that I last saw him alive on 8-1 1945

Immediate cause of death	DURATION
Pulmonary tuberculosis	11 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: 8-2-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73d)

CERTIFICATE OF DEATH

08254

★ Reg. Dist. No. 2405

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Prince Georges
City or town Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3505 - Perry St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Louis Theophilus ZBinden

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband~~ or wife AGNES KING
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 24, 1864

8. AGE: Years 81 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Greenville, Ill.
(Town, county, and state)

10. Usual occupation Auditor

11. Industry or business U.S. Govt.

FATHER
12. Name Louis H. C. Zbinden
13. Birthplace Switzerland

MOTHER
14. Maiden name Louise H. Bonville
15. Birthplace France

16. Informant Mrs. Agnes Zbinden
Address 3505 - Perry St. Mt. Rainier, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 22, 1945 (month) (day) (year)
Cemetery or crematory Cedar Hill Cemetery
Location Suitland Rd. & D.C. Line

18. Funeral director William J. Nalley
Address 3200 - R.I. Ave. Mt. Rainier, Md.

19. Aug 21 1945 (Date rec'd by registrar) James Levey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 19 1945, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 1940, to Aug 19 1945
and that I last saw h~~e~~r alive on Aug 5 1945

Immediate cause of death	DURATION
(a) Myocarditis	4 yrs
Due to	
Due to	
Other conditions Hypertension	4 yrs

(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Leonard Hoyt M. D. or other
Address Hyattsville, Md. Date signed Aug 21 1945